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**A study of organizational dynamics
and environmental influences in the
development of a drug abuse center for youth.**

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A STUDY OF ORGANIZATIONAL DYNAMICS
AND ENVIRONMENTAL INFLUENCES IN THE
DEVELOPMENT OF A DRUG ABUSE CENTER
FOR YOUTH

A Dissertation Presented

By

LON DeLEON

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

February 1986

School of Education

Lon DeLeon



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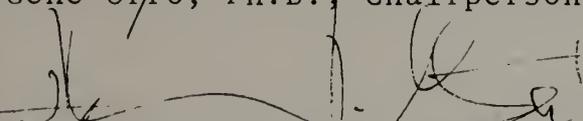
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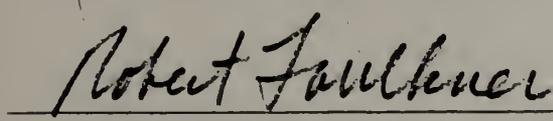
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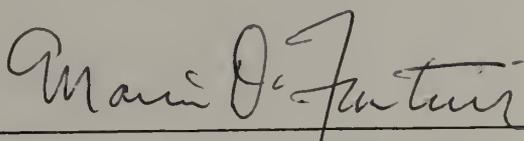
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To my mother who instilled in me the will to not give up; to my sons Ripon and Woodrow who are my inspiration; and to my wife Margaret whose sacrifice, devotion and encouragement made this possible.

To my committee members, Dr. Orro, Dr. Faulkner, and Dr. Gentry for their professional guidance and support.

ABSTRACT

A Study of Organizational Dynamics and
Environmental Influences in the Development of
a Drug Abuse Center for Youth

(February 1986)

Lon DeLeon, M.Ed., University of Massachusetts,

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Directed by: Dr. Gene T. Orro

This study shows three distinct phases in the development of a drug abuse program: (1) the Missionary Phase in which the program is struggling against policies and situations which are perceived by the original leader as compromising the therapeutic mission of the organization; (2) the Hybrid Phase in which a split between the research and treatment goals are in conflict and threaten the continuance of the program; and the final, (3) Survival Phase in which policies and philosophy are altered in order to meet utilization demands to ensure survival of the organization.

It is a study of a human service agency providing treatment services to adolescents with drug abuse problems.

The Youth Program it examines is actually a sub-organization of a larger multi-service drug treatment agency, The Drug Treatment Unit, which was established in 1968. The larger unit provides an example of past and current governmental approaches to the treatment needs of drug abusers, while The Youth Program represents a new and creative addressing of the same problem.

This study is being conducted at a time when the austerity of public funding sources (i.e., federal, state and local governments) threatens the existence of all programs regardless of their proven record or current promise. In this study of the treatment methods, organizational dynamics and external influences, it is intended that a clearer picture will emerge from the relative efficiencies and the role external government policies play in the development of such programs. Special attention is given to the internal operations and the possible impact of external policies which can determine future continuance.

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C H A P T E R I

INTRODUCTION

"In The Temple of Science are many mansions. . .
and various indeed are they, that dwell therein
and the motives that have led them there. . ."

Albert Einstein (1918)

In acquiring specific knowledge in the drug field, one will find the literature is concentrated in four general areas: treatment, medical, legal, and educational. Although highly empirical, much has been published in the area of drug treatment. Among the books most helpful are those describing different modalities of treatment. The therapeutic community (Jones, 1953) approach is discussed in two works on Daytop (Casriel, 1963) and Synanon (Yablonsky, 1965). Also, in the 1977 American Journal of Drug and Alcohol Abuse, there is a good historical review of Drug Free therapeutic communities (Glaser, 1974). In these works, an in-depth description is given of the philosophy of "concept" programs and their actual working operation of the communities of ex-addicts who assist each other in the process of rehabilitation. A combination of the professional and non-professional (Densen-Gerber,

Murphy, 1973) therapeutic community approach to drug treatment is of interest. Methadone maintenance (Hentoff, 1969) is documented by a presentation of the ideas and beginning works of Marie Nyswander with addicts in New York City. Recent developments (Brill, 1967; Brill, Jaffee, Laskowitz, 1967; Dole, 1969; Kleber, 1977) in the therapeutic use of methadone and results of active programs provide an idea of the current status of methadone as a form of treatment. There is also a significantly interesting paper within the 1979 American Sociological Review entitled Government Policy and Local Practice (Attewell & Gerstein, 1979) which is a case study of a methadone program's attempts at complying with government policies regarding the use of methadone. It analyzes the effects and problems of compliance to the government policies and indicates where the policies appear in direct conflict to the goals of the clinic, such as: age eligibility required by the Government is seen as an impediment to providing a methadone treatment response to younger addicts by the clinic; Government requirements for urine collection is seen as an alienating, nonessential process by the clinic; restriction on client information regarding methadone dosage levels is seen as contrary to open information policies pursued by the clinic. It is also perceived by Attewell and Gerstein that compliance with these Government regulations may paradoxically shorten the

clinic's life by severely alienating the client population to a point where they no longer choose to participate in the treatment. Though the organization of this study does not utilize methadone as a part of its treatment, it is subject to similar Government policies which are of the utmost concern to this study.

Another chemotherapeutic approach is the use of antagonists, naloxone and cyclazocine, which were utilized by the Youth Program in the second phase of its existence. Several studies (Freedman, 1966; Resnick et al., 1969) explain the use of cyclazocine; additional studies (Freedman et al., 1967, Jaffee & Brill, 1968) covers the dysphoric or side-effect reactions of cyclazocine and naloxone upon clients. Further studies (Resnick et al., 1971) indicate methods to minimize side effects of cyclazocine when used in treatment. Studies on the toxicity (Volavka et al., 1975, 1976) and the safety of antagonists (Braude & Morrison, 1976) are also of interest. There has been little published on naloxone (Goodman & Gilman, 1970) because of its minimal use in drug programs. Federal attempts at rehabilitation (Livingston, 1958; Sells, 1976) are reviewed in government publications on the work done at Lexington and Fort Worth. Some work has also been done with the use of LSD-25 as a means of treatment (Stafford & Golightly, 1967).

The difficulties of detoxification of drug addiction (Moffett, Soloway & Glick, 1973) is explained in studies following inpatient hospital detoxification. The withdrawal syndrome (Wilker & Pescor, 1967) and its relapse potential, and the use of methadone for detoxification (Newman, 1977) gives one an idea of the problems associated with detoxification with or without aftercare treatment (Isbell & Vogel, 1948). There are also recent developments regarding the use of Clonidine (Gold & Kleber, 1977) for the use of detoxification from methadone maintenance.

It is of interest to review historically the changing views of treatment clinicians (Terry & Pallens, 1928) in order to understand how we got to where we are today (Musto, 1973) regarding the American drug problem. What occurred in the 50s and 60s (Glasscote, Jaffee, Bell, & Brill, 1972) is of interest in order to gain an understanding of the developments leading to today's methods and models. A review of psychiatric responses (Conrad, 1977) is important since mental health and psychiatry is a major influence on the field of treatment for drug addiction.

A review of the background of drugs and the law is helpful in providing a framework for understanding current practices (AMA, ABA, 1966; Coles, Brenner & Meagher, 1970; Sonnenreich, 1969). The law and its relationship to treatment (McGlothlin, Anglin & Wilson, 1978) and the effects on

criminal behavior (Austin & Letteiri, 1976) and whether treatment in fact reduces crime is a major concern to future treatment.

It is also important to distinguish poly-drug abuse (Wesson, 1978) from non-opiate drug abuse (Benvenuto & Bourne, 1975). It is especially important in understanding the young drug abuser as a client of this organization. So many of the young addicts coming into treatment are taking more than one psycho-active drug (Tinklenberg & Berger, 1977) which can complicate treatment. For example, methadone may be appropriate treatment for heroin dependency (Sells & Simpson, 1976), but not when abused in combination with barbiturates and/or amphetamine dependency.

There is some literature of major relevance to the issues of drug abuse and young people (Block, 1975) such as studies that indicate high risk in students in grades 7 to 12 (Letteiri, 1975). There are relevant studies of students (Blume, 1969) and (Ray, 1972) which use correlates between user and non-user to determine high risk. Another study (O'Donnell, 1976) describes an association between drug use and delinquency. In an anthology of papers on prediction of adolescent drug use (Letteiri, 1975), one learns that drugs are accorded different meanings in the lives of users (Goldstein, 1975; Kovacs, 1975); that deviance in drug use is associated with other kinds of

unusualness and that one can become preoccupied with a drug-centered life (Nurco, 1972); that consistent or convinced drug users are psychologically different from others, being more interested in sensation-seeking (Segal, 1975), and being low in self-esteem, coping and psychological well-being (Linbald, 1977; Norem-Hebeisen in Letteiri, 1975). They demonstrate ego deficiency and regressive tendencies (Naditch, 1975) and high intensity euphoria-seeking in their early alcohol use (Block, 1975). Evidently several years prior to beginning drug use, users can be differentiated from others on the basis of being rated as more rebellious, untrustworthy, impulsive, and less self-reliant, ambitious, interested in school, socially accepted, and also less academically confident (Smith & Fogg, 1975). Emotional distress is also a differentiating factor (Mellinger, 1975). Intensive users may also be, in a selected academically successful sample, more creative (Mellinger, 1975) and are more likely interested in humanities, arts, and the social sciences (O'Donnell et al., 1976).

Each of these is important but none are outstanding discoveries. To this point it can be said that the thrust of the literature regarding adolescent drug abuse in the areas of epidemiology, sociology, or psychology has been to confirm and extend earlier notions of adolescent deviance

and drug taking.

There is an extensive array of literature in the area of medical effects of drugs. For the nonscientist, basic reading might range from the simple (Lingeman, 1969) to the intermediate (Goodman & Gilman, 1970) and advanced (Wikler, 1967). Specific drug classifications can be concentrated on, e.g., opiates (Wilner & Kassebaum, 1965); barbiturates (Cameron, 1965); and marijuana (Hughes, 1971; Solomon, 1966).

In the general area of education, including sociology and psychology, there is now virtually tons of literature. Drugs and their relation to society (Barber, 1967; Blum, 1969) is a good starting point. Alienation (Keniston, 1967) and the counter culture (Roszak, 1968; Becker, 1966); and psychological perspectives (Miller, 1967) will give one a real foundation for understanding and further reading.

C H A P T E R I I

METHODS USED IN THE STUDY

Participant Observer

The methods and procedures utilized in this study though relatively new to institutional evaluation are best explained by the term "participant observations" (Becker, 1958; Goffman, 1961). From being involved in the development and implementation of the organization, the researcher decided upon this study based on the historical analysis of the 1978-1983 period, observations and personal notes and other data gathered during the operational years of the organization.

Beatrice Webb, a renowned researcher, wrote in her field diary in 1932, while doing a study on coal miners:

July 16. Sitting for five or six hours in a stinking room with an open sewer on one side and ill-ventilated urinals on the other is not an invigorating occupation. But in spite of headache and mental depression, I am glad I came. These two days debate have made me better appreciate the sagacity, good temper and

fair-mindedness of these miners than I could have by reading endless reports.

Ms. Webb also concluded in her work Methods of Social Study (1934):

The study of a social institution is made by observations and analysis, through personal participation or watching the organization at work, the taking of evidence from other persons, the scrutiny of all accessible documents, and the consultation of general literature.

This is the approach this researcher takes, drawing from those experiences, documents, and people relevant to the study of the Youth Program. The action, role, findings, and conclusions of the participant observer will be followed by the reflection of its potential meaning and impact on the field and as an academic study.

Throughout this study the researcher has attempted to draw on the works of numerous writers and the experiences gained in working directly within the organization in various capacities. The researcher first entered the organization during its initial development as a clinical assistant while on the staff of Yale University's Drug Dependency Institute. While in this capacity the researcher had a day-to-day involvement with the organization of this study, attending staff meetings, planning sessions,

conferences, and therapy sessions. This experience was followed by five years of developing and administrating similar treatment organizations for the Medical University in South Carolina. It was during this period that the researcher also served as a consultant to the State Alcohol and Drug Abuse Commission which provided a first hand knowledge of state and federal policies regarding drug abuse.

During the five year absence from the organization of this study, the researcher maintained consistent contact with the organization through periodic visits and conversations with leadership and staff before permanently returning to the organization as a staff member of the Department of Psychiatry at Yale and the Drug Treatment Unit (the parent organization).

The data for this study was obtained from interviews with past and present staff and clients, and from thousands of pages of typewritten notes developed by the researcher over the five year period in which the researcher was again an ongoing participant of the organization. The actual participation in daily organizational activities served to enhance the understanding of direct and subtle influences upon the organization.

Since this is a study of the development of one component of a larger organization, it could be argued that the

organizational structure of the program was relatively loose (especially during the early stages of development when the program was quite small). It could also be argued that the use of the participant observer technique raises the question as to whether the study is more of a reflection of personal experience than an organizational analysis. This is an observational study in which the researcher was present during the three phases of the organization's life.

The sources of data are participant observations, informal open-ended interviews with past and present staff and clients, and official documents relevant to the organization. In effect, the study examines the separate ideologies which arise from the interests and values within the organization's environment. An evaluation is made of their relative contributions to organizational performance. The way in which the organization changes or does not change as different models and structures emerge is an important concern of this study.

In analysis, the reports of the participant observer are developed as narratives of the organization's development and performance over a period of time which is according to current practice. The observer did not only look at relationships of specific members, but at the overall patterns of the organization's development and performance. Variables examined were organized in terms of the mission,

leadership, staff, and budget of the organization.

Evaluation in the area of the behavioral sciences has made advances in the past century, not only in the increase in tools available for the quantification of the data, but also in the recognition of the many diverse methodologies needed to begin to understand why individuals and organizations behave, function, or operate as they do. The procedure to be employed here present a relatively new way of approaching institutional evaluation in the area of drug abuse. In this case, I, the "participant observer," was not originally contracted with the agency for the purpose of evaluation. Rather, as stated earlier in this study, the author was an employee who after working in the formulation and implementation of the organization decided on the need for such an evaluation.

The final outcome could best be termed a "case study" (Clark, 1968), for while making some generalizations, the research concentrates in depth on one organization, the Youth Program.

The selection of this particular design is made for several reasons. First, in the evaluation of "Broad Aim" social programs, experimental design creates technical and administrative problems so severe as to make the evaluation of questionable value (Weiss & Rein, 1970). The experimental model has been criticized by Stufflebeam (1968),

Suchman (1968), and Schulberg and Baker (1968) as being intrinsically unsuitable to the evaluation of broad aim social programs. A more historically oriented, more qualitative evaluation has more value (Weiss & Rein, 1970). Second, the case study approach has enabled the researcher to analyze several different aspects of the organization incorporating various research designs which will then allow the presentation of a total picture of the organization, showing the interrelation of all the segments. In addition, the organization will be presented with the most applicable type of research for self-understanding and possible change.

The data will constitute a review of original documents (grants and contracts); relevant statistical information compiled in the data keeping system, informal interviews, and conversations with members of the organization; evaluation of the style and quality of leadership, intra-agency relationships and politics; and personal observations and participation.

This study, though covering the full life span of the organization, will concentrate on the five years of 1979 to 1983. The early history of the Youth Program will be discussed in regard to historical analysis.

Procedures

1. The reconstruction through historical analysis the goals, theories, philosophy, and original purposes of the project.

2. The tracing of the development and organization of the project vis-a-vis the initial functioning stages of staff development and assimilation and the running of the first "research" approach through a hybrid "research/treatment" approach to a final "treatment" approach.

3. The documentation of critical interventions both internal (intra-organizational) and external (social and environmental) and analyze effects on the goals and functions of the organization.

4. The evaluation and documentation of performance in terms of meeting original goals and purposes of the program.

5. Recommendation of strategies for mitigating effects and suggest more plausible modes of organization.

Organizations in the Environment

It is a current assumption that a service organization should operate within the tolerance points of its environment. The organizational-environmental interface must match up with those of its segment of the environment if

healthy transactional relations are to prevail (Lawrence & Lorsch, 1969).

Recent literature on the study of organizations suggest that there are certain basic principles operating in their development. For this research, of primary consideration in this process is the major part that external elements play in influencing the internal structure of the organization. These elements tend to shape the goals, philosophy, and functioning of the organization (Selznick, 1943). There is no indication that human service or public agencies are exempt from this influence.

In this study, the environment is made up of four policy-making agencies ranging from the national (federal) level down to the local organizational (program) level.

These agencies are:

1. N.I.D.A. (The National Institute on Drug Abuse). This is a federal sub-bureaucracy within the National Department of Health, Education and Welfare set up by congressional mandate to address the nation's drug abuse problems. In operating its mandate to establish national policies addressing the drug abuse problems in this country, N.I.D.A. manages and expends all federal funds and resources for research, treatment, education, and prevention in the area of drug abuse.

2. C.A.D.A.C. (The Connecticut Alcohol and Drug Abuse Council). This is a state bureaucracy managing both federal and state policy and resources for addressing the problems of alcohol and drug abuse within the state of Connecticut. This agency receives both federal and state funds which it allocates out to local organizations involved in the fields of alcohol and drug abuse.

3. C.M.H.C. (Community Mental Health Center). The purpose of this agency is to provide treatment, research, and training in the areas of mental health, alcohol, and drug abuse. The services range from inpatient psychiatric (there are designated beds within the inpatient unit for alcohol and drug abuse crises and detoxification) to day care services of five hours a day or more, to outpatient services. Research activities are ongoing and included in the day-to-day functions of the agency.

4. D.T.U. (The Drug Treatment Unit). This component of the Community Mental Health Center was established in 1969 to accomplish research, treatment and training specifically in the drug abuse area. The D.T.U. is the parent administration of the Youth Program which is the organization of this study. The Youth Program was established as a component of the D.T.U. to address the particular problems of youthful drug abuse.

These four organizational groups are the key to understanding the structure of influence and the politics of budgets. The four policy-making groups of the National Institute on Drug Abuse include The Connecticut Alcohol and Drug Abuse Council, The Community Mental Health Center, and The Drug Treatment Unit which do interact. They act as layers through which the Youth Program sends its requests--upward, as it were (see Chart I). Flowing back and towards the Youth Program are parameters for action, budgets and allocations and programs for accountability. Thus, the target organization receives guidelines from the four levels and personnel above it in this chain of action. In this process, it seeks to plan for the future, allocate services, carve out a mission for itself, motivate its personnel, and develop the commitment of its members.

The next section looks at the Youth Program itself, how administrators and staff execute policy in fulfilling the program's mission. Next we pay close attention to how the organization deals specifically with the layers of other significant organizations in its relevant environment.

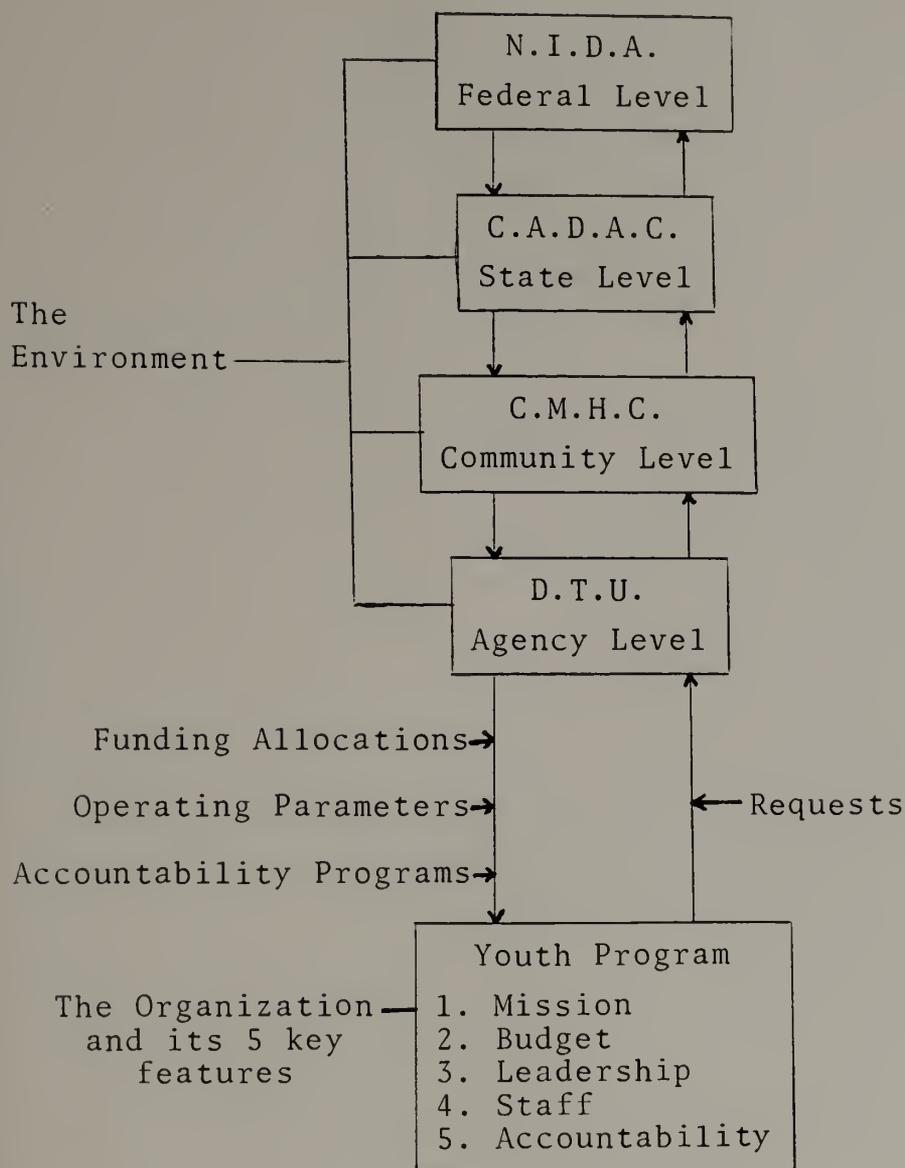
The Organization (The Youth Program)

In any public service organization, there are several key features which demand study in order to understand how they operate. They are:

CHART 1

The Environment and the Organization

Activity Flow Chart



Arrows pointing up ↑ indicate requests by the target organization.

Arrows pointing down ↓ indicate dollar allocations to the organization.

1. Mission
2. Budget
3. Leadership
4. Staff
5. Accountability

Each of these five key features is responsive to changes in the environment and each of the five features impact and change the environment. This will be called an enacted environment. As the organization acts and reacts along these dimensions, it brings into being its own particular environment.

1. Mission. In this study, the mission of the organization moves through three phases: from a mental health oriented "research model" through a hybrid "research/treatment model," to a final "treatment model." We are interested in how the organization of activities are structured within each model (see Chart II). We will also focus on the difficulties accompanying the transition periods from one stage to the next, showing the influences of organizations in the environment on the transitions.

2. Budget. In this study, the budget of the organization moves through the three stages from a "research" budget of approximately \$100,000.00, through a hybrid "research/treatment" budget of approximately \$245,000.00, to a "treatment" budget that ends at approximately

CHART 2

Organizational Life in Three Phases

The life of the organization is seen in three distinct phases:

PHASE I (Research Model) ----- (Research/Treatment) ----- PHASE II (Treatment Model) PHASE III

Crucial to this study is the analysis of the changes within the five (5) key features of the organization as it moves through the evolutionary process of these three phases:

	PHASE I	PHASE II	PHASE III
1. Mission	Research	Hybrid Research/Treatment	Treatment
2. Budget	Approx. \$100,000 per annum	Approx. \$245,000 per annum	Approx. \$230,000 per annum
3. Leadership	Intellectual soft, loose, rational	Intellectual/Political mixed, irrational	Political, strict, tight, rational
4. Staff	(6) Academic/Research	(10) Academic/Service	(20) Service
5. Accountability	Low	Mixed	High

\$230,000.00 within the study period (see Chart II).

In public services where annual grants are the norm of agency existence, the budget plays an integral part in both the nature of services offered and the degree to which staff pursue them.

One way the budget operates is as a "spending plan" for the organization. It is like a planning menu that breaks out in specific portions the ingredients that the organization requires to meet its mission. In this situation, the budget is developed by the organization through negotiations with the funding sources; The Connecticut Alcohol and Drug Abuse Commission and the National Institute on Drug Abuse, and then it is utilized as a forecast statement of how the organization intends spending its funds.

A review of the total allocations by the funding sources within the three particular phases of "research model" through "research/treatment model" to "treatment model," along with an analysis of the organization's "spending plans" provides concrete data as to how enabling or restrictive the budget is. Given the present state of this economy, all essential human services are underfunded. How enabling or restrictive the budget is depends largely on the creativity and executive ability of leadership.

3. Leadership. In this study, the leadership changes as it moves through the three phases. It moves from a "research" oriented loose, intellectual and rational approach through an irrational "research/treatment" hybrid approach of a mixed intellectual and political type to a rational "treatment" orientation of a strict political approach.

Outside of environmental influences, leadership is purported to be the most critical modifier of organizational behavior (Fiedler, 1971). The leader is considered the controller and delegator of all resources and must deal in some way with the concepts of power, control, influence motivation, direction, and authority in the delegation of duties and responsibilities. The study of an organization, therefore, must document the specific type of leadership employed and how the above concepts were operationalized.

An analysis of the leadership or command structure of the Youth Program during the evolutionary process of the program's movement through the three models will indicate how leadership interacts with the environment and is in turn a product of environmental influences as is the nature and structure of the organization's staffing pattern.

4. Staff. The documentation involved in this study reflects the changes in staffing patterns and staff composition, resulting from the evolution of services. The staffing composition moves from the initial "research model" of six (6) academic research staff through the hybrid "research/treatment model" of a mixture of ten (10) academic and service-oriented staff to the complete "treatment model" of ten (10) service oriented staff (see Chart II).

In community-responsive human service agencies, a more or less prominent factor in staffing is the inclusion of community workers. Dependent upon the relative interests or action orientation of the target population, this factor can play a major role in personnel determination. This is another of the influences proceeding from the environment that shape the organization.

5. Accountability. In this study, the amount and type of accountability moves through the three phases where the accountability is initially low through a hybrid "research/treatment" phase where the accountability is mixed to the "treatment" phase where accountability is high.

Organizations today providing any of the human services suffer or benefit from an enhanced visibility. All agencies and services are subject to continual public

scrutiny and audit. In the area of evaluation, three major concerns arise under the aegis of accountability: (1) prudent and effective expenditure of funds, (2) program impact, (3) program effort, and (4) quality of service.

C H A P T E R I I I

BACKGROUND DATA

"Discovering the Need"

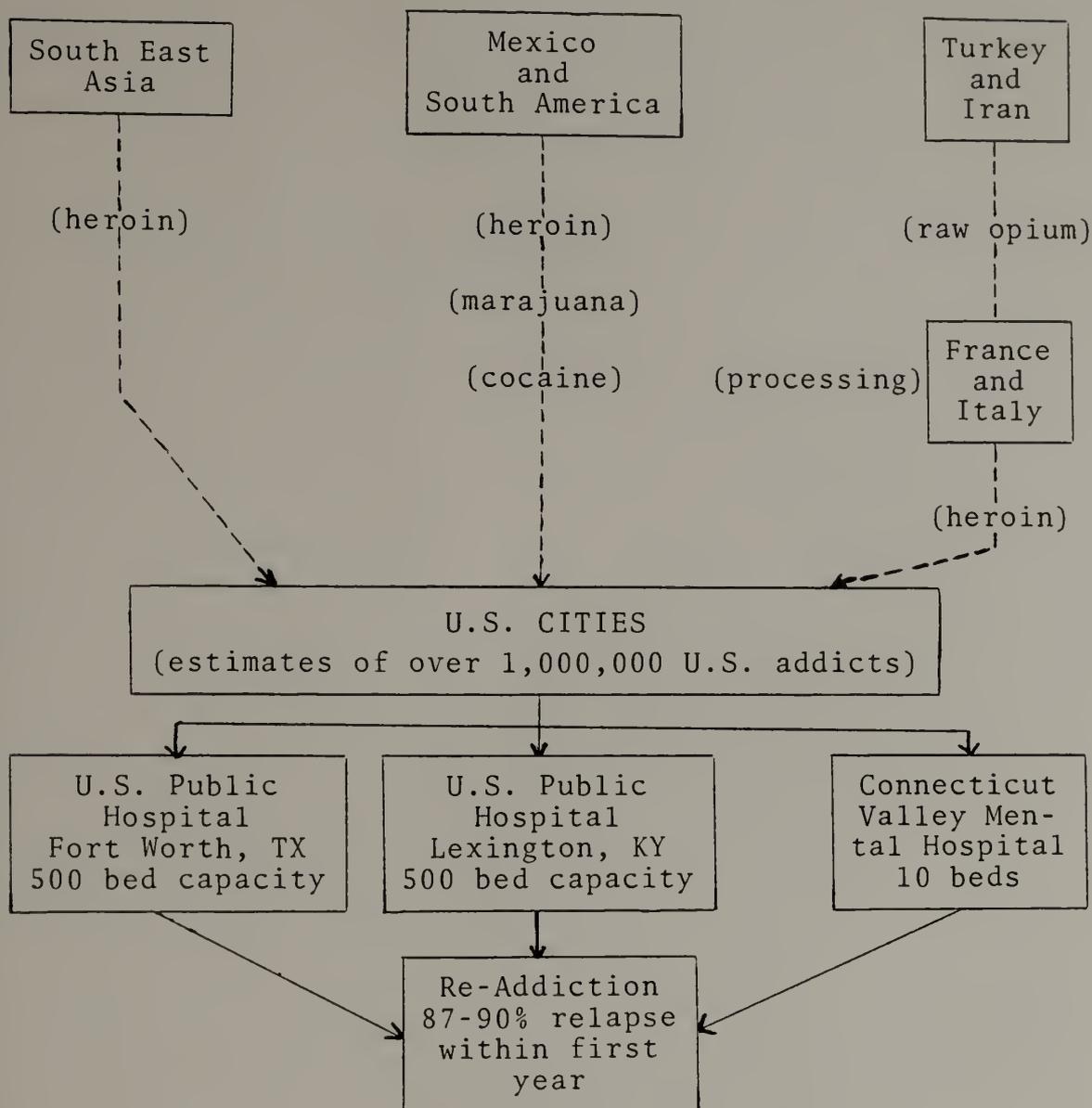
State of affairs of professional and community response to drug problems at the time of the establishment of the parent agency--local, state, national, and international considerations.

Environment

At the time of the development of the parent organization, The Drug Treatment Unit, there were clear indications in the country of a major drug problem. Drug treatment programs of the United States Public Health Services at Lexington and Fort Worth were being flooded with addicts and were operating far above capacity throughout the early and mid 60s, regardless of their high failure rate. Reports from all the major cities, from health institutions to law enforcement officials, supported the major increase in addicts (see Chart III).

CHART III

U.S. Drug Problem and Treatment Organizations
Prior to 1968



-----> represents drugs
 —————> represents addicts

State Scene

Despite its high income per capita and relative small urban areas, Connecticut was not spared its share of the American drug problem. There had been a constant and major increase of drug-related deaths, arrests, and health encounters from the late 1950s and throughout the early and mid 1960s. The Connecticut Valley Hospital (C.V.H.), a state-operated mental institution, had set up a 21-day drug detoxification program which utilized methadone in decreasing doses over a 5 to 21-day period to relieve the discomforts of drug withdrawal. The return rate to drugs and to the hospital itself of those treated at C.V.H. was as bad or worse as that of the Lexington and Fort Worth programs. It became obvious to the hospital staff and the community in general that this model was not working. Most individuals, close to 90%, left the hospital as soon as their medication ran out. Some even continued to use drugs while in the hospital. To everyone involved, it seemed like an endless, costly and perpetual process that intervened minimally and at best temporarily in the addict's addiction. Law enforcement officials were discouraged, health officials were disappointed, and the hospital's staff were not only discouraged and disappointed, they also seemed defeated. This defeat was clear in the lack of attention or involvement the staff had with the

addicts. The addicts were admitted to the hospital, given their doses of methadone, and then left to vegetate with no therapeutic activity other than a television set and a deck of cards.

Local Scene

Dating from the early 1960s, New Haven had a large heroin using population for a city its size. By 1968, law enforcement and health officials estimated the addict population at 2,000 with an additional 1,000 or so non-addicted heroin users. There was no valid treatment to speak of. Most addicts ended up in jail, prison, or hospitals like C.V.H., Lexington, or Fort Worth, and became part of the "endless cycle."

It was in this difficult climate of 1968 that the community Mental Health Center applied for and received a major grant award to develop drug treatment studies. The grant was submitted to the National Institute of Mental Health (NIMH), a sub-bureaucracy of the Department of Health, Education and Welfare (see Chart IV).

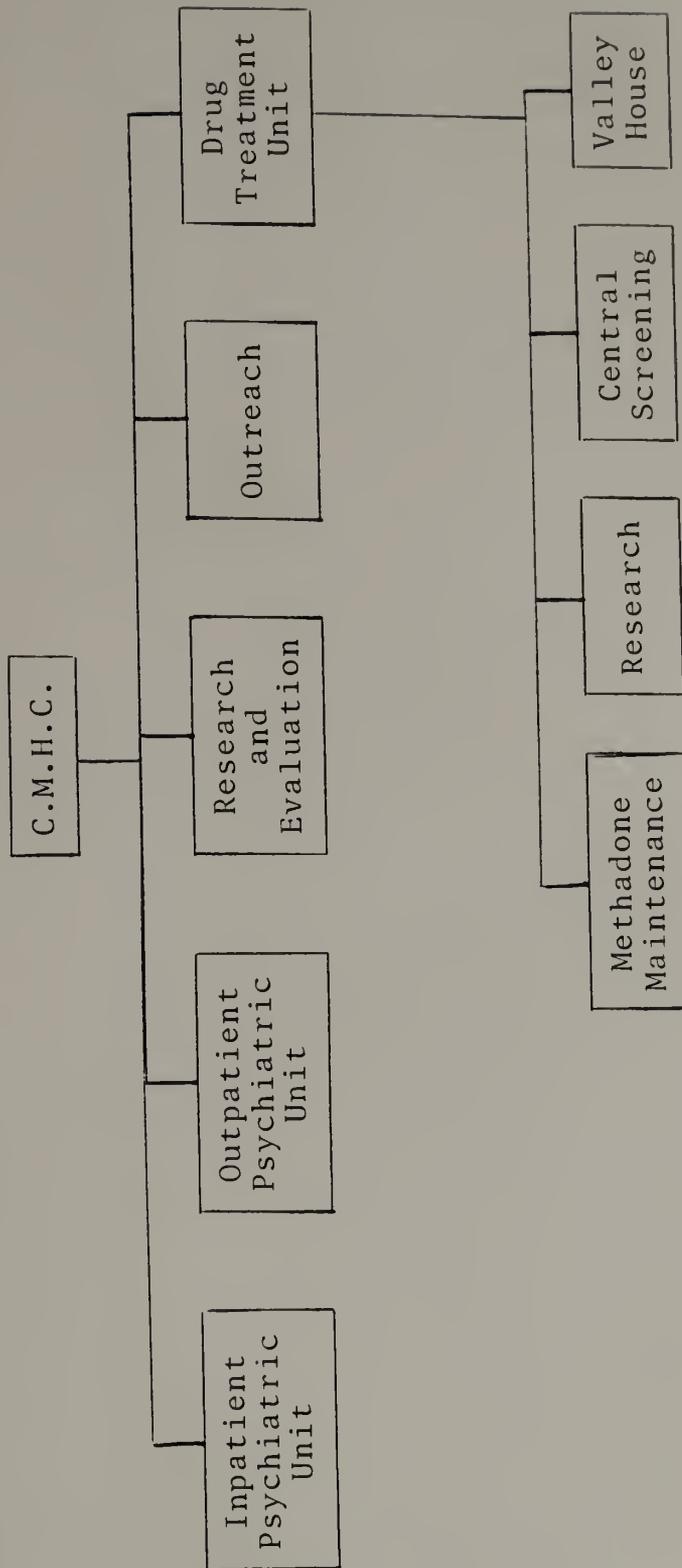
Methadone at height of popularity

The United States Congress, openly influenced by the methadone research studies of Drs. Marie Nyswander and Vincent Dole (A Medical Treatment for Dicetylmorphine

CHART 4

The Drug Treatment Unit Organizational Chart

The original award established the Drug Treatment Unit as a drug treatment component of the Community Mental Health Center as indicated in this 1969 C.M.H.C. organizational chart (prior to the development of the Youth Program).



[heroin] Addiction: Clinical Trial with Methadone Hydrochloride, published in 1965), and in the well-publicized claims of Synanon, the first drug treatment therapeutic community, legislated financial support in 1966 to develop community-based voluntary treatment programs. Those dollars were channeled through the Department of Health, Education and Welfare to the National Institute of Mental Health, which acted as both sponsor and monitor of drug treatment expenditures by the federal government. As sponsor, N.I.M.H. advertised an interest in receiving grant requests to do research and treatment studies for drug addiction.

N.I.M.H. received proposals from various universities and mental health centers around the country. It was evident at this time that N.I.M.H. was interested--if not exclusively, certainly particularly--in methadone maintenance proposals.

The original award to the Drug Treatment Unit was to set up both the methadone maintenance and the therapeutic community models in the New Haven area. It was an eight-year award, totaling over a million dollars, to be spread out over the eight-year period of 1968 to 1975. The thrust of the initial grant was to develop a methadone maintenance program for 50 addicts from the inner city of New Haven, and a therapeutic community (Valley House) for an

additional 30 addicts. This was to establish these as research experimental models which were studied for impact and outcomes.

The grant award from N.I.M.H. provided 90% of the program's budget, with a 10% portion to be obtained either by state or local sources. This 10% could be obtained in "soft match" which is considered goods or services. These goods or services were applied to the overall budget to make up the total cost of the project per annum. The state or local portion of the award was to become greater each year over the eight-year period, with a final 60% being supplied by state and local sources, and the federal N.I.M.H. share reduced to the remaining 40% portion of the budget.

Parent Organization
(The Drug Treatment Unit)

There were three major components of the Drug Treatment Unit. These components, each with its own head, were: the Methadone Maintenance Program, Valley House (a therapeutic community), and also a separate research component. Valley House at this time related to the Drug Treatment Unit on a contractual basis.

Methadone Maintenance Program

Initially this program required inpatient hospitalization in the Community Mental Health Center for periods of between four and eight weeks. In the fall of 1968, an attempt was made to accommodate patients on an outpatient basis without any initial inpatient stay. However, this arrangement did not work out well, and a day hospital program evolved which subsequently became the mainstay of the program.

Patients came in Monday through Friday from 8:30 a.m. to 4:00 p.m. During this time they received their methadone and were involved in a variety of therapeutic and rehabilitative measures. Urines were checked twice a week for narcotics, quinine, amphetamines, barbiturates, and cocaine. The great majority of the patients were either in school, vocational training or steadily employed. In addition to receiving methadone, patients continued to remain in group therapy for at least six months after being discharged from the day hospital program. In the first year of operation, the program had 55 members. Their median age was 32; the median years of addiction was 12.

Valley House

Valley House is a residential therapeutic community staffed entirely by ex-addicts who are Valley House graduates. The staff arrived in New Haven in August of 1968, and until November of 1968 were housed in a building too small to permit admission of new patients. During that time period, prospective patients were referred to the Valley House facilities in another state. In November, a temporary facility was found which housed 25 patients and served as their base of operation until June of 1969 when a new facility was located. In November of 1968, the staff of Valley House voted to disassociate themselves from their parent organization and incorporate as a nonprofit corporation. A board of directors was formed comprised of local citizens and professionals. In June of 1969, Valley House moved into a building in a suburban area which is approximately 25 minutes from the Community Mental Health Center and The Drug Treatment Unit. This facility accommodated 50 patients and provided a place to carry on all phases of its therapeutic work.

Research

This section was responsible for the operation of the data gathering and record keeping systems. A long range epidemiological study and the techniques for overall program evaluation were also planned.

C H A P T E R I V

PHASE I: THE MISSIONARY PHASE

"Honorable Rehabilitation at All Costs"

Conception of the Idea

With the establishment of the methadone maintenance program and the Valley House therapeutic community for the adult "hard core" addicts, the Drug Treatment Unit became a focal point for all drug problems in the area. As a result, a situation developed that had not been anticipated. The leaders and staff were also being constantly called upon by families, schools, and local authorities regarding the need for treatment of younger drug abusers who did not meet the methadone or Valley House admission criteria. These contacts, toward the end of the D.T.U.'s third year, became so frequent that the Assistant Director of the organization was given the time and the responsibility to provide some evaluation and counseling services to the parents and the younger drug abusers. At this time, some were being met on a weekly basis by the Assistant Director for counseling; others were referred to the C.M.H.C. for mental health counseling; and others were

being sent to the state mental institution (Connecticut Valley Hospital) for detoxification.

It was from this situation that the Assistant Director of the D.T.U. originated the concept for non-adult drug abusers. The idea for such a program was developed during the summer of 1973. The Youth Program (the organization of this study) actually began in late May of 1974 with an additional grant award provided through the National Institute of Mental Health to the Drug Treatment Unit. The program was to serve area residents under the age of 21 who suffered from drug abuse problems. The idea was to design a program and test it, modifying and changing it where necessary, in order to have a viable and relevant model that would operate on a regular basis, starting in the fall.

Application for Funds

Early in 1972, the Drug Treatment Unit thought it had a working model for a youth drug treatment program. Logic would have it that an effort would be made to find a funding source; however, as happened, the funding source found the program. This is an important point, for it demonstrates how at an early point in the program's development, external sources exerted considerable influence on what was to become the Youth Program. The three external

sources at this time were the Community Mental Health Center, the Drug Treatment Unit, and the National Institute of Mental Health.

Writing the Grant Proposal

The Director of the Drug Treatment Unit, in his frequent talks with officials of N.I.M.H. in Washington, D.C., mentioned the idea for a youth drug treatment program and included it in his annual report, as it was a part of the activities of the D.T.U. This was met with interest and the "word" was passed that N.I.M.H. was about to release bids for treatment of adolescent drug abusers.

The Assistant Director of the D.T.U., then went about the task of writing the proposal. Although the proposal was written by the Assistant Director, keep in mind that the goals, philosophy and direction, as well as coming from innate ability and experience in the pilot programs, were heavily influenced by the staff and the agency (D.T.U.) that he worked for and was a part of. The following are sections of the proposal, which although lengthy, must be included here because of the inherent nature of the writing and how it represents the development and initial phase of the youth program:

[Goals and Philosophy:] The basic philosophy behind the Youth Program is that youths make their own decisions about drug use, and that

a treatment program can provide them only with better information and tools with which to make these decisions. On the one hand we reject exhortations and threats as treatment tools, and on the other we reject the notion that the presentation of facts themselves will suffice. We hold that a sound treatment program for youth must have much more than either of these.

First of all, a treatment program must have goals. Without question, one of our goals is to decrease the incidence of drug abuse. We do not, however, hope to indoctrinate youths into our personal philosophy on the use, misuse and abuse of substances. We do hope to transmit our information and our knowledge on decision making, to enable youths to make better decisions based on their own priorities and needs. We hope to intervene in the sub-culture to cause the group to re-evaluate its position on the safety and utility of drug use. We are prepared to provide certain guidance and informational inputs in this effort, and we are prepared to accept the youths' decisions whether they correspond to our prior notions of propriety or not.

Finally, it is our feeling that for drugs to become ultimately less attractive to youth, key social institutions must become more relevant and attractive. To this end we encourage parents, teachers, and administrators to think through with our staff what changes can be made in content and attitude in the home and in school to make them more relevant to today's conditions of living.

Overview of Phase I of the Project

The Youth Program was administered by the Community Mental Health Center through the Drug Treatment Unit. In the first phase, the Youth Program was physically located just down the street from the C.M.H.C. within a brownstone rooming house which had been renovated to house the D.T.U.

programs. (This site of the program is discussed in further detail later on in this chapter.) The Youth Program moved into a section of the brownstone directly next to the outpatient adult methadone program of the D.T.U. At this time, attention was not being given to the potential impact, negative or positive, of the Youth Program's sharing a facility with the methadone program whose philosophy was essentially quite different.

The Youth Program was begun on a relatively small scale, in comparison to the methadone program, offering outpatient treatment for eligible youth from the New Haven and surrounding 13 town catchment area.

Though the Youth Program could employ specialists from private practice or non-related agencies for special needs, the greatest strength of the program was its access to a comprehensive treatment program (D.T.U.) and the subsequent availability of many leading practitioners and theoreticians in the field of drug abuse and adolescent behavior.

All treatment was tailored to the specific needs of each individual. Schedules and content of activities were negotiated in a series of pre-treatment meetings between the treatment staff and the prospective client. Ordinarily the treatment included: (1) individual counseling, (2) group counseling, (3) interaction with clients, and (4) seminars.

These individual sessions were designated to make the clients familiar with the problems of drug abuse and the likelihood of future consequences. The counseling was also used to establish trust and inspire clients to express true feelings and work toward more responsive attitudes and understanding of self.

Whenever a client entered a group, the individual brought with them varying amounts of suspicion, hostility, uneasiness, feelings of inadequacy, and fears of rejection. Those feelings tend to remain below the surface and can impede the process of the individual in the group. The experience in these cases is often diluted by unnecessary competitiveness and destructive one-upmanship maneuvering. Groups were set up to deal with these problems before they occurred. The group model was said to be the social group work model rather than the "T-group" model. Through study of the group work theory and through actual participation in groups, clients were expected to learn how to organize and conduct themselves in appropriate ways.

The best way to become familiar with the problems and experience of drug abusing young people was to talk with them. The clients and staff, therefore, would spend a considerable amount of time in groups asking questions and being asked questions, discovering "hang ups," biases, and blind spots. And hopefully, within the process, they

would learn how to recognize and deal with their prejudices and problems.

In these seminars, clients would reflect on their treatment experiences, evaluate their efforts and understandings, and evaluate the experience the treatment had provided.

Clients were expected to synthesize all that they had learned and to develop a rather broad outline of how they intended to utilize their new knowledge and understandings.

Notification of Award

In the early spring, the D.T.U. administration was informed that the proposal would be funded at approximately the level of \$100,000 to begin June 1, 1974. The acceptance of the proposal had to do primarily with three factors:

1. The National Institute of Mental Health was just beginning to move into the area of treatment for youthful drug abusers. Monies granted previous to this had been in the area of adult treatment, primarily methadone maintenance and therapeutic communities for "hard core" addicts. For the program, it was a case of being in the right place at the right time with some sound program experience.

2. The heads of the National Institute of Mental Health held the Drug Treatment Unit in high regard. It

was considered one of the most successful and innovative programs of all the projects funded to date. The grant to begin the Youth Program was viewed in Washington as being an extension of the services of the already successful D.T.U.

3. The impression that the D.T.U. Director made in Washington as a person, competent and knowledgeable in the field, also had direct bearing upon the proposal's approval.

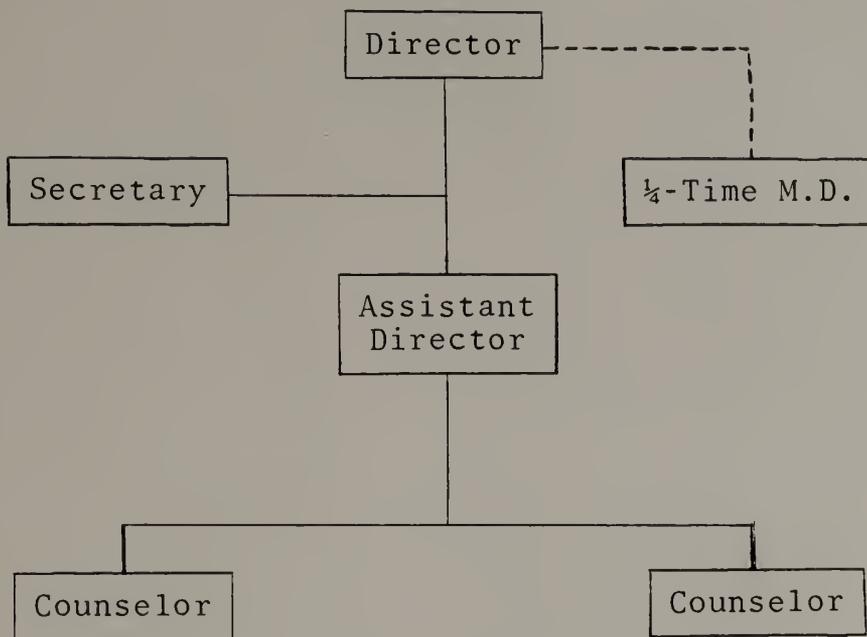
So in a sense, a new baby was born, but a baby which still was very much attached to its mother--the Drug Treatment Unit. Although funded through the Community Mental Health Center and accountable to the Center's Director on paper, in practice, the Youth Program and the D.T.U. were one. The assistant Director of the D.T.U. became the Director of the Youth Program and retained his former title as well.

Accountability

The accountability within the first phase of the Youth Program was primarily from the funding source, N.I.M.H., and other state licensing agencies such as the State Department of Mental Health which licensed the C.M.H.C. itself. The accountability was minimal and took the form of written reports at the end of the funding

CHART 5

Organizational Chart of the Youth Program
--Phase I



period, along with financial statements and audits regarding the expenditure of all funds for the program. The annual report to N.I.M.H. was actually a performance statement by the program indicating how many clients the program had seen over the funded period and how long they had stayed in treatment. Twice a year N.I.M.H. also sent out field monitors to visit the programs and meet with the staff in order to obtain a direct impression of how things were going, according to guidelines set forth in the proposal and award.

The more significant accountability was within the D.T.U. itself, and was carried out primarily in staff meetings where components of the D.T.U. came together to coordinate their services and air their problems and differences. The actual performance of programs was based upon criteria that the D.T.U. had developed as operational goals of (1) urinalysis reports, (2) program attendance, (3) school and/or employment, and (4) arrests.

Operational Goals

Urinalysis

All clients within the D.T.U. programs were expected to provide a urine sample at least once a week. This sample was sent to a laboratory for a drug screening. A "clean urine" meant the client had no illicit drugs within

his/her system for over a 48-hour period. A "dirty urine" indicated the individual had taken a drug and was therefore in violation of any "drug free" boundaries. (Within the methadone program, three consecutive "dirty urines" could mean expulsion from the program.) The Youth Program did not adopt this rigid a policy. "Dirty urines," in the Youth Program, were considered a breach of program trust and subject to privilege loss.

Within the first phase, a majority of urines tested indicated the clients maintained an active involvement with drugs. This reflected upon the model and performance of the program, especially since other D.T.U. programs were able to boast of a very small percent of "dirty urines" on all clients following 60 days of entering the programs.

Program attendance

This was based upon the number of scheduled treatment encounters the client kept with the program. The intent of the program was to increase the number of encounters to an optimal level where behavior improved and "dirty urines" no longer occurred. Once the urines were clean on a regular basis (60 days), the treatment encounters ideally would then gradually decrease through a reentry process of developing community support such as employment, school,

training, etc. to a final "graduation" from the program.

School and employment

All clients entering the program had either school or employment problems. In the first phase, the program found little improvement actually took place in this area. Clients continued to have problems in school and continued to be unemployed or in difficulty with their jobs. This ultimately led to the program deciding in the second phase that the clients would stay within the program and not attend school until there was significant improvement in their behavior and attitude toward school. The clients did receive some basic tutoring from staff while at the program, and upon completion or during reentry, the clients were expected to return to school or become gainfully employed in order to graduate from the program.

Arrests

An aspect of the drug abuser's reality are frequent brushes with the law. Clients within the Youth Program were no exception. In the first phase, there was a strong feeling that many of the clients who left the program were arrested and placed in jail or other programs; the actual figures were not available. According to staff, during this phase, it seemed they spent a great deal of time in

meetings with police, probation officers, and courts.

The Budget

The budget during the first phase was primarily a staff-salary budget established by the parent organization. There was no staff participation in the budget. It provided for the salaries of the Youth Program Director, the Assistant Director, two counselors, a quarter-time M.D. for medical evaluations, and a secretary.

There was another 10% for fringe benefits and an indirect cost of 12.5% to the C.M.H.C. for managing the grant award.

Space and supply costs were also built into the budget. The space cost was shared between the larger methadone program which occupied one side of the brownstone, while the Youth Program occupied the other side.

Leadership

The initial leader of the Youth Program, as already indicated, was established prior to the development of the program and was singularly instrumental in its development.

The first Director was a social worker who had obtained his drug abuse experience on the city streets of Patterson, New Jersey where for six years prior to joining the D.T.U. as Assistant Director, he had worked with street

gangs in one of Patterson's ghettos. He came to the D.T.U. with an expressed interest in working with younger addicts and once on board led a campaign in staff meetings to develop services for addicts who were too young for the methadone program and not interested in Valley House.

He viewed drug abuse as a manifestation of intolerable social conditions. The young addicts were perceived as "victims" or "delegates" of these poor conditions which was a reflection in the orientation of the original model. He saw the role of the Youth Program as attempting to improve the client's social conditions while at the same time working toward strengthening the client's ability to tolerate and overcome those conditions.

To this reviewer, he always appeared as a strong-willed, charismatic leader who was always struggling against forces which were either threatening the program or the clients. It was when this struggling got pitted against D.T.U. interests and policies that he began to lose control of the program.

In meeting start-up objectives, he was open and sensitive to the needs and ideas of staff and spent a major amount of his time listening and offering support. He encouraged free expression of staff ideas and allowed staff the freedom to be creative. Toward the end of the first year, however, as the program was experiencing mounting

problems of client deviance and "drop outs," he became more closed, distant, and task-oriented. He continually rallied against D.T.U. policies and interests which ultimately became his undoing. The conflicts that developed primarily resulted from the parent organizations refusing to allow the Youth Program the autonomy it needed to proceed in a different direction.

D.T.U. senior staff meetings at this time were made up of the D.T.U. Executive Director, the D.T.U. Medical Director, D.T.U. Administrator, and the program directors of Methadone, Valley House, and the Youth Program.

These meetings became taken up continually with problems stemming from the Youth Program being so closely located to the Methadone Program. There were ongoing confrontations between the Youth Program Director and the Methadone Program Director over what the Youth Program Director considered a lack of control of the methadone clients by the methadone program, especially on the front porch and street corner in front of the program's building. There was a constant occurrence of drug dealing to the younger clients by the older methadone clients, and visa versa, as well as incidence involving sexual acting out by clients in both programs. There had been a number of reported incidents within the Youth Program itself where a methadone client was discovered in sexual activity with a

Youth Program client. There were similar reports of Youth Program clients being caught in sexual activity in the Methadone Program. Along with this were complaints by Youth Program parents that the older Methadone Program clients were showing up at their homes to pick up their children. This situation culminated in an attempted abortion by one of the Youth Program clients who had been made pregnant by a methadone client who was no longer in the program, and was said to be back using and selling drugs.

At this time, even a casual observer could see that the Methadone Program enjoyed superior status to the Youth Program even though public priority indicated the opposite should be true. This was born out in the statement of the Methadone Program Director in a staff meeting when he informed the Youth Program Director, "If you don't like it, you and your program can leave." It is not clear whether this statement represented a personal or organizational point of view. It was definitely an alienating factor in terms of the morale of the staff of the program.

This all led to another campaign by the Youth Program Director to obtain a separate site for the Youth Program. Initially the D.T.U. did not want to add to the space cost of the program and also did not want to get into the difficulty of setting up another building. However, time after time, incidents between the clients of both programs

resulted in long drawn out combative staff meetings in which the Youth Program Director finally charged the D.T.U. seniors and the Methadone program of sabotaging the Youth Program by its inappropriate location. From this observer's point of view, at this time this problem was an obvious product of the lack of specific planning for the Youth Program that resulted from its subsidiary position to the Methadone Program. As such, if the success of the Youth Program was a priority, it was an organizational mistake.

Another major controversy developed around the Youth Program Director's attitude toward the urine collecting policy. It was his opinion that the policy of collecting urine on the Youth Program clients weekly was at cross purposes with the Program's primary task of establishing intimate and trusting relationships with the younger clients which he viewed as requisite to any therapy which was to occur. He argued the clients felt threatened that the urine reports would fall into the hands of parents, probation officers, school officials, or other "outsiders." He also felt that it was demeaning to the clients and staff. He argued, to no avail, that the urine policy was actually methadone regulations established by the American Food and Drug Administration (FDA) and the Bureau of Narcotics and Dangerous Drugs (BNDD) for the purposes of

monitoring and controlling methadone program dispensing. Since the Youth Program did not utilize methadone, or any other chemicals at this time, as a part of its treatment, the policies, he argued, were therefore inappropriate and served no good purpose to the Youth Program.

Throughout the first phase, the Youth Program maintained a high incidence of "dirty urines," especially in comparison to the methadone program and the Valley House program. This "trend" of "dirty urines" became viewed as the Director's inability to develop a sound treatment program. This was contributed to by the already indicated restraints placed on the Director and the subsidiary status the program had within the overall organization.

The last straw for the D.T.U. seniors came when the Youth Program Director openly opposed a research project (the Naltroxone and Cyclazocine chemical "antagonist" study which took place in the second phase of the program and is discussed in the following chapter). The study was being proposed as a joint venture of Yale University, the Community Mental Health Center, and the Drug Treatment Unit.

To the Youth Program Director, the study was being proposed at a time when the program was just moving out from under the negative shadow being cast by increasing doubt of the efficacy of the methadone approach and the potential problems of being so closely linked to a parent

organization using such an approach. The Youth Program Director now argued that the research study would place an additional burden upon a program in a stage of essential change and might negatively effect the successful implementation of that change.

At this time, resistance to the research study was taken by the D.T.U. seniors as a direct opposition to their research and treatment interests which was unavoidable given the organizational structure. It was not long after that the Youth Program Assistant Director transferred to another C.M.H.C. component he seemed disillusioned with the Youth Program. The D.T.U. then decided to transfer a staff member from Valley House to become the Youth Program's Assistant Director.

Since the Youth Program had been moving in the direction of "concept" programming similar to Valley House, it seemed natural to transfer someone skilled and experienced in its approach to help the program along. To the Youth Program Director, it was a direct undermining of the authority and control essential to his position. At first he attempted to adjust, spending most of his time in direct treatment with clients and families, avoiding administrative and personnel activities. Nevertheless, the situation became untenable and he resigned in the fourth year of the program.

Staff

Following are some of the significant issues surrounding the resignation of the Program Director.

The staff, during this phase, was made up of the Assistant Director and two counselors. One of the counselors was an ex-addict client of the Methadone Program who had impressed the D.T.U. leaders with his motivation and intelligence. The other had come to the program through the C.M.H.C. where he had been working as an aide on one of their inpatient floors. The Assistant Director was also a social worker who had worked with the Program Director in New Jersey and was hired by the Director based upon this past working relationship. The quarter-time physician was a pediatrician on board at the Mental Health Center who was assigned to do medical and physical examinations of the Youth Program clients. Toward the end of this phase, the Valley House staff person transferred as Assistant Director was also an ex-addict who had graduated the Valley House program before becoming a staff member. (This individual later became the Youth Program Director and is discussed in following chapters.) To what extent this staffing pattern effected the ultimate of the Youth Program is discussed in subsequent pages.

There was a strong distinction of theory within the D.T.U. between the Youth Program staff, the Methadone Program staff, and the Valley House staff. In the beginning, it appeared that the leadership of the Drug Treatment Unit and the Community Mental Health Center were committed to a distinctly separate style of programming for the younger drug abusers. Their philosophy seemed rooted in advocate counseling, psychotherapy, and family mediation as the focus of the program. It became obvious following the program's first two years of performance that their commitment was eroding, and support was being given more to the notion of "concept" programming similar to that of Valley House.

The performance of the Youth Program in the first phase of its development convinced the staff and leaders that outpatient treatment of individual counseling and therapy was relatively ineffective. The clients continued to use drugs and get into trouble at home and in the community. The majority of clients dropped out of the program within the evaluation stage, and those that stayed were constantly falling into crises resulting from drug taking and acting out.

Even though the staff shifted the emphasis from a loose "here and now" group process to a more confrontive and then confrontative style, along with specialized groups

such as "heroin groups" for heroin users and "head groups" for psychedelic drug users and "speed groups" for amphetamine users, the outcome was still unsatisfactory. The outpatient model, they believed, was just not enough intervention for this age group. It left the younger clients with too much time on their own. It was this thinking that led to a full day model similar to that of the Methadone Program's day hospital program. The younger clients were now expected to be within the program from 9:00 a.m. to 5:00 p.m., Monday through Friday. It was in this "full day" program that the incorporation of the "concept" model began.

The First Change in Focus

The day program

This was a more structured approach to dealing with the younger clients. The day was filled with groups, tasks, meetings, and activities designed to confront and challenge the behavior of the clients. The morning began with a "general meeting" at 9:00 a.m. sharp. This meeting was chaired by a client who had been selected by the staff the previous day. The meeting lasted an hour and reviewed the events of the previous day, accepted any information regarding occurrences the previous evening and night, then went on to the coming day's agenda and expectations. It was in this meeting that direct feedback was given about

client performance. There would be compliments and insights by staff and clients, and there would be criticism, advise and direction to those not performing well.

This meeting was followed by tasks and duties from the washing of floors to the filling out of forms or the planning of program activities. There was a client hierarchy established with leaders called "coordinators" who had their assistants called "expeditors" who then had their workers called "workers." The coordinators were the client leaders who were set up to communicate all program business to the staff, and also from the staff to the clients.

It was with this model that retention rates improved. Client behavior and staff morale also improved.

The D.T.U. leadership, seeing what they considered a clear direction, decided to go all "the way" and totally embrace the treatment philosophy of "concept" for the Youth Program. Valley House had come to play a major dominant role in the D.T.U. converting significant organizations and individuals to its therapeutic philosophy called "concept," and also by placing its graduates in staff positions in other D.T.U. components. The Youth Program's evolution offers a good example of this development. The Youth Program, it can be said, began as a fairly conventional social work clinic. Gradually, though, as this relatively easy-going approach to drug treatment

seemed to be failing, the Youth Program staff introduced more and more structure into the program.

Site and Setting

This area of observation is extracted and given a separate treatment due to the clinical and management issues that were involved in location and housing.

The city of New Haven is situated on the Connecticut coastline approximately 100 miles north of New York City and approximately 150 miles south of Boston. It has an inner city population of 126,000 people. As the home of Yale University, with a resident student body of 10,000, it is a metropolitan cultural center with a downtown area made up of the University's campus which spreads throughout the city and a large downtown shopping mall dominated by a large Macy's department store.

Bordering the city on the northwest and southwest are two large ghettos--the Congress Avenue and Hill section, and on the northwest the Dixwell Avenue Newhallville section. These ghettos are made up of worn public housing projects and old tenement buildings which house New Haven's lower socioeconomic groups which are primarily black and hispanic. There are 16,000 residents in the Congress Avenue and Hill section and another 14,800 in the Dixwell Newhallville section. It is from these two ghettos that

most of New Haven's drug problems are said to reside. The drugs come into New Haven from the larger cities of New York and Boston and are sold primarily out of these areas of New Haven.

The Community Mental Health Center (C.M.H.C.), built in 1966, has a mandate to provide mental health services to these ghetto residents and is located a few blocks from the Congress Avenue ghetto. The C.M.H.C. is a new ultra-modern five-story red-brick and mortar building resembling a small modern hospital.

It was within this new ultra-modern setting that the Drug Treatment Unit was established as New Haven's first drug treatment program. It began as a methadone maintenance program occupying five beds on the C.M.H.C.'s third floor. This was an inpatient psychiatric floor of 20 beds total. At this time, all drug clients were first brought into the center for an inpatient stay of five to seven days while they were inducted onto methadone and then stabilized on a daily dose before being released to outpatient status. The client was then expected to return to the third floor daily for their dose of methadone. This situation in time resulted in problems for the Center's staff and patients. By the end of the first year, there were over 60 drug clients visiting the third floor daily to get their methadone. Chronic complaints by the Center's staff regarding

the aggressive and abusive behavior of the methadone clients became a regular occurrence in all the C.M.H.C.'s executive staff meetings. There were complaints of fights between drug clients and mental health patients; there was also a string of thefts and incidents of sexual acting out by the methadone clients in which they were being caught in sexual activity with the mental health patients, and also making overt gestures and propositions to the Center's staff. The culmination of these complaints and problems led to a decision by the heads of the C.M.H.C. to move the drug program's outpatient activities out of the Center.

According to conversations with the Drug Treatment Unit's Director, it was his impression at the time that most of this was from the C.M.H.C. staffs' inexperience and biases in dealing with drug clients. Moving the program, according to him, was not for the purpose of improving services, but to placate a staff who were not properly trained nor interested in servicing the needs of the drug program and its clients. He also felt that the clients were easily able to perceive this which led to a resentment which added dramatically to the problems.

In the second year of the program's development, the D.T.U. was able to lease a building one block down the street from the C.M.H.C. A three-story brownstone rooming house, it is divided into separate sections with two

separate entrances. The space was renovated into offices with a dispensary and clinic area on the first floor of the left side of the building. This area has become the home of the methadone program within New Haven.

The Youth Program's first site

The impact of close proximity to the Methadone Program was the most outstanding feature of the initial site.

It is clear that any institution or program which claims that individual treatment is being carried on within its walls will need to take seriously the impact of "institutional hygiene" (Redl & Wiseman, 1965). By this is meant the demand that every aspect of program life be so designed as to support the basic trends of the treatment goal and be carried out in such a way that it at least does not do damage to the treatment process. This was not the case with the first site of the Youth Program. The intent behind a separate program for young drug abusers was to keep them apart from older more "hard-core" addicts who, it was felt, might exploit or manipulate the younger addicts and be a negative influence upon their treatment. Irregardless of this concern, the Youth Program was developed within the other half of the three-story brownstone directly next door to the Methadone Program and a block down the street from the ultra-modern C.M.H.C. facility. At the time of the

Youth Program's development of the Drug Treatment Unit programs, only the methadone day hospital (where new methadone clients would go for four weeks of group therapy and induction onto methadone while still residing at home in the community) and the D.T.U. Director's office were actually located in the Community Mental Health Center itself. The Methadone Program and the Drug Treatment Unit physician and assorted other personnel occupied the other half of the brownstone building. The remaining Drug Treatment Unit components were scattered throughout the New Haven area.

The first floor of the Youth Program had four rooms--the office of the Youth Program Director, a secretary's office, a bathroom for clients, and an interviewing room. The second floor also had four rooms--the Assistant Director's office, a counselor's office, a group room, a client lounge, and a bathroom for staff. The third floor had an office for another counselor which doubled as a meeting room and staff lounge. There was also an office for client use which doubled as a conference room "hang out" for the clients.

In back of the building is a small parking lot, and in front is a porch which was shared with the Methadone Program as mentioned earlier in this study. It was on this porch that the conflicts between the clients from the two programs took place.

This close proximity of the two programs meant that keeping the younger clients separate from the influences of the older clients and visa versa was not likely. For in order to gain access to the Youth Program, one would have to pass through groups of methadone clients milling about in front of the building or on the front porch. In very short time, this situation developed into problems for both programs. Drug dealing, prostitution, sexual liaisons between clients within both programs became daily occurrences that the program leaders and staff had to contend with.

The methadone staff, having first occupied the building, saw the Youth Program as an intruder creating conflicts similar to that which had developed within the Mental Health Center. This time the decision was made by the Drug Treatment Unit, with the coaxing of the Youth Program, to relocate the Youth Program to a less compromising location where the program could get about the business of treating the younger addicts without the conflict drag of the Methadone Program in its way.

The second site

In 1976, another building was finally located three blocks from the Methadone Program. This was at the time when the Youth Program was moving to the day-program model

which required more space than the first site since the clients were not at the program for at least five-hour durations.

This was a two-story clapboard residential building with a small fenced-in yard surrounding it on three sides and a driveway, and parking area for four cars on the left of the building. The first floor has six large rooms--the Director's office, the secretary's office, two large counseling offices, a meeting room which doubled as an interview room. The second floor has another six large rooms which were used as group rooms and meeting rooms as well as staff and client lounges. There was a client bathroom downstairs and a staff bathroom upstairs.

There had been an unsuccessful attempt at making the building seem casual and homelike rather than a clinic or office building. However, the amount of offices and the furnishings which were C.M.H.C. hand-me-downs denied any feelings of homelike atmosphere. As the program in the second phase became a residential program (this is discussed in the following chapter), the building was slightly renovated. This amounted to some plumbing work, painting, and new doors for front and back entrances. The extent of the renovation was in adopting the upper floor's six rooms as residential bedroom space for 15 clients and utilizing the lower floor for offices and treatment space.

The sites of these programs were selected primarily due to their close proximity to the Community Mental Health Center, more importantly because they were available and the Drug Treatment Unit felt at the time they were able to obtain local approval to use them for drug programs. This approval was actually by the Mayor's office, zoning, and city planning.

The buildings were not originally designed for the purposes they were put to, which gave the impression of the programs being thrown together, adding a strong feeling of impermanence to the programs. The buildings were not selected with a serious eye to the future. The second site clapboard building finally had to be abandoned in two years after the roof was falling in and the clients and staff were being rained upon in offices and bedrooms. This was along with a total breakdown of the boiler which it was said, at times heated the building.

In this hardship situation, the program was allowed, by approval, to move into a closed section of the local YMCA building, again just down the street from the C.M.H.C. This was no small feat at the time.

The goings-on at the Methadone Program as over 300 addicts were enrolled and attending the brownstone on a regular basis alarmed and outraged certain members of the community. Fights, thefts, accidents, overdose, muggings,

prostitution, drug dealing, even an attempted murder, over the years, occurred with some regularity on the corner, or the porch, or the back parking lot of the methadone clinic. This situation made all local drug programs suspect irregardless of their size, type, and performance. The Youth Program was a part of the Drug Treatment Unit, and it was a drug program; thus the immediate community felt threatened. It was the D.T.U. Director's pleas to the Mayor, along with support by the Community Mental Health Center and Yale University, that turned the trick. The YWCA administration and board of directors, after being contacted by the Mayor's office, accepted a one-year lease arrangement stating that the program would have to use that time to seek another location. The program, however, has remained within the YWCA renewing the lease year after year, not being able to find a suitable alternative site in the area.

This location within the YWCA also resulted in an increase in space, especially residential, for the program.

There were two floors assigned to the program within the four-story building. The first floor of the building was the administrative and treatment floor of the program. The second floor directly above was used primarily as additional bedrooms with meeting rooms and group rooms as well. Both floors were on a "T" shape with offices and

group rooms being on the upper smaller part of the "T" and the bedrooms being on the remaining longer corridor.

There was a total of 18 bedrooms on the lower floor and another 20 on the upper floor, each were double rooms.

The program did not, during the time of this study, utilize all of the bedroom space. The program did expand and take in more clients and the building became a more permanent home to the program.

C H A P T E R V

PHASE II: THE HYBRID PHASE

"A House Divided"

After the administrative changes had occurred as a result of the events listed in the previous chapter, other factors arose to shape the future fate of the Youth Program.

Major changes in the funding arrangement of the Youth Program took place within the third year. In 1972, the United States Congress enacted the Drug Abuse Office and Treatment Act (public law 92-255) which established the National Institute on Drug Abuse (N.I.D.A.). The role of N.I.D.A. has been characterized by a vigorous research into the biomedical, clinical, behavioral, and psychosocial variables or causes of drug abuse prevention, treatment, and rehabilitation resources throughout the country. The underlying intent was to be able to provide help for any person seeking it.

Slot-Cost Funding

N.I.D.A. in 1973 became the primary funding source of the Drug Treatment Unit programs, as the National Institute

on Mental Health (N.I.M.H.) shifted all of its resources and responsibilities for drug abuse problems to the National Institute on Drug Abuse (N.I.D.A.). As one of its first items of business, N.I.D.A. went about adopting a new method of funding for drug treatment programs. The method of funding under N.I.M.H. for these programs had been grant oriented; N.I.D.A. in 1974 instead adopted a "slot-cost" model of funding for the D.T.U. programs. Within the "slot-cost" framework, the program support became based upon the projected utilization of capacity to deliver a given mix of services (in the case of the Youth Program, residential, day services, outpatient) to a population of clients, rather than a conglomerate of itemized individual services selected by the program and rendered to the clients.

Through national cost-analysis studies, along with prevalence and utilization studies, N.I.D.A. determined that there were four primary types of treatment "slots": inpatient hospital, residential, day services, and outpatient. Each slot category then had a specific financial sum attached to it.

In the case of the D.T.U. programs, N.I.D.A. established the inpatient detoxification slots within the Community Mental Health Center (C.M.H.C.) at \$20,000.00 per bed per annum. N.I.D.A. had also established the

maximum stay for detoxification was 21 days. The average was more like 7 to 10 days, which meant that if the bed was filled every day of the funded year, it could serve approximately 73 addicts for the \$20,000.00 rate.

Residential services such as Valley House and the Youth Program were established at \$5,000.00 per slot per annum. The average stay within either of these programs at this time was approximately 18 months.

Day services were established at \$2,500.00, and were also considered an 18-month average stay.

Outpatient services, which included the Methadone Program, were established at \$1,700.00 per slot per annum. The average length of stay on most methadone programs at this time was over two years.

The Youth Program, like all of the D.T.U. programs, had been developed prior to slot-cost funding. Conversion to "slot-cost" funding meant justifying its level of funding based upon an active number of registered clients and a plan projecting future utilization.

Inpatient hospital facilities had traditionally been based upon the number of "beds occupied," so this system was not as radical a departure for residential or inpatient programs. It did, however, represent a movement away from the payment per visit and per procedure model used to support outpatient programs that evolved from the

fee-for-service model adopted by the Medicaid and Medicare programs.

At the start of the "slot-cost" arrangement, the Youth Program seemed to have an abundance of clients and future applicants, the D.T.U. seniors were able to use this to negotiate an increased level of funding support for the program. The final contract with N.I.D.A. was approved for:

- 30 residential (therapeutic community) slots
@ \$5,000.00 per slot per annum.
- 25 outpatient slots @ \$1,700.00 per slot per annum.
- 15 day service slots @ \$2,500.00 per slot per annum.

Funding totals:

30 slots x \$5,000.00 = \$150,000.00

25 slots x \$1,700.00 = \$ 42,500.00

15 slots x \$2,500.00 = \$ 37,500.00

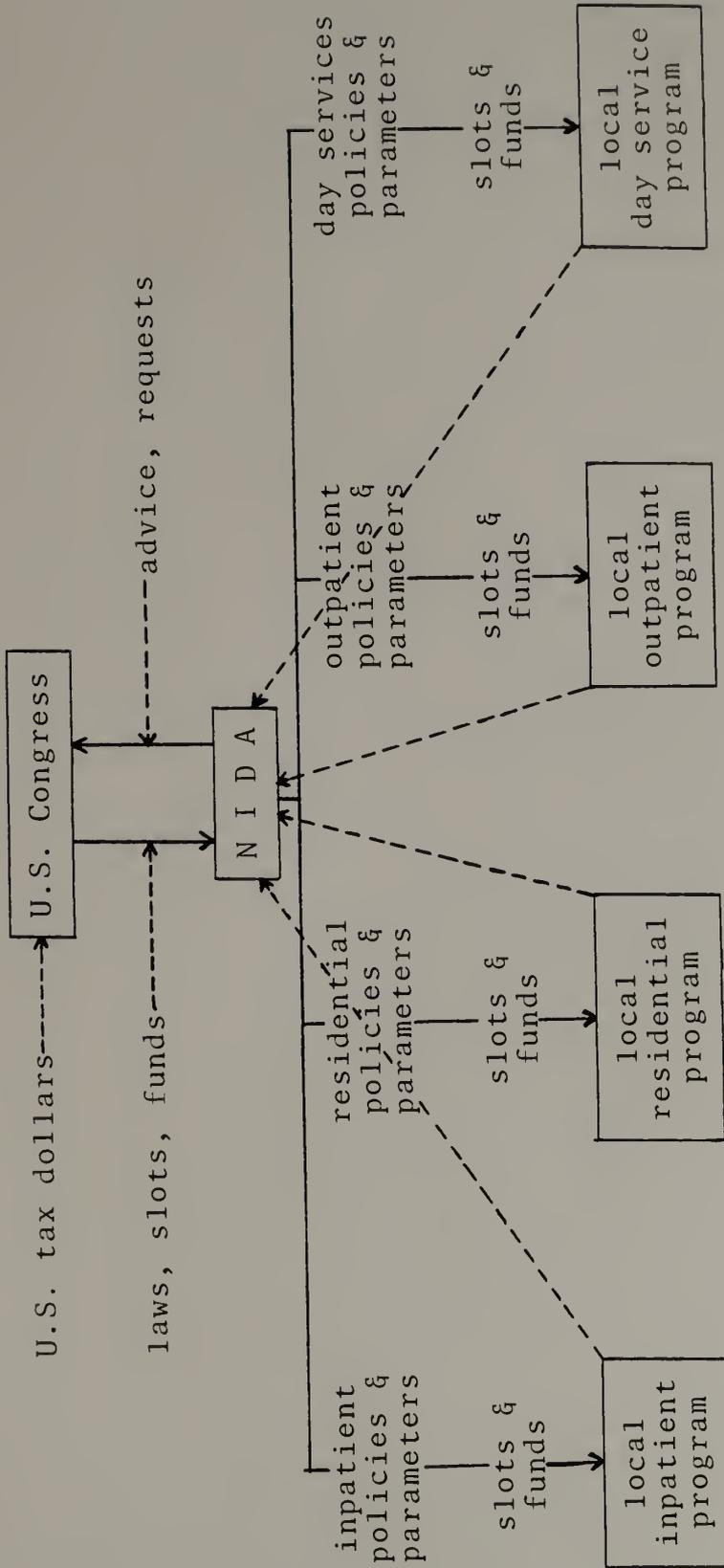
Total:
\$230,000.00

This \$230,000.00 was provided at the start of the funding year to the Drug Treatment Unit by N.I.D.A.

This slot-cost model, like the "occupied bed-day" model for hospitals, motivates programs to keep slots filled in order to maintain funding. Stating it simply, N.I.D.A. received from the United States Congress funding for 90,000 treatment slots to be dispersed nationwide. It was N.I.D.A.'s job to allocate those slots to organizations

CHART 6

Federal System of Funding for Drug Treatment Programs in 1974



Arrows pointing up ↑ to NIDA indicate requests by local organizations.

Arrows pointing down ↓ represent allocations to the local organizations.

it felt could provide viable services to enough clients to justify and maintain ongoing utilization of those slots.

With the increased level of funding, the Youth Program became a multi-service agency. The program, while still under the authority of the Youth Program Executive Director, was now divided into specific components with separate staffs, as in the following 1975 organizational chart.

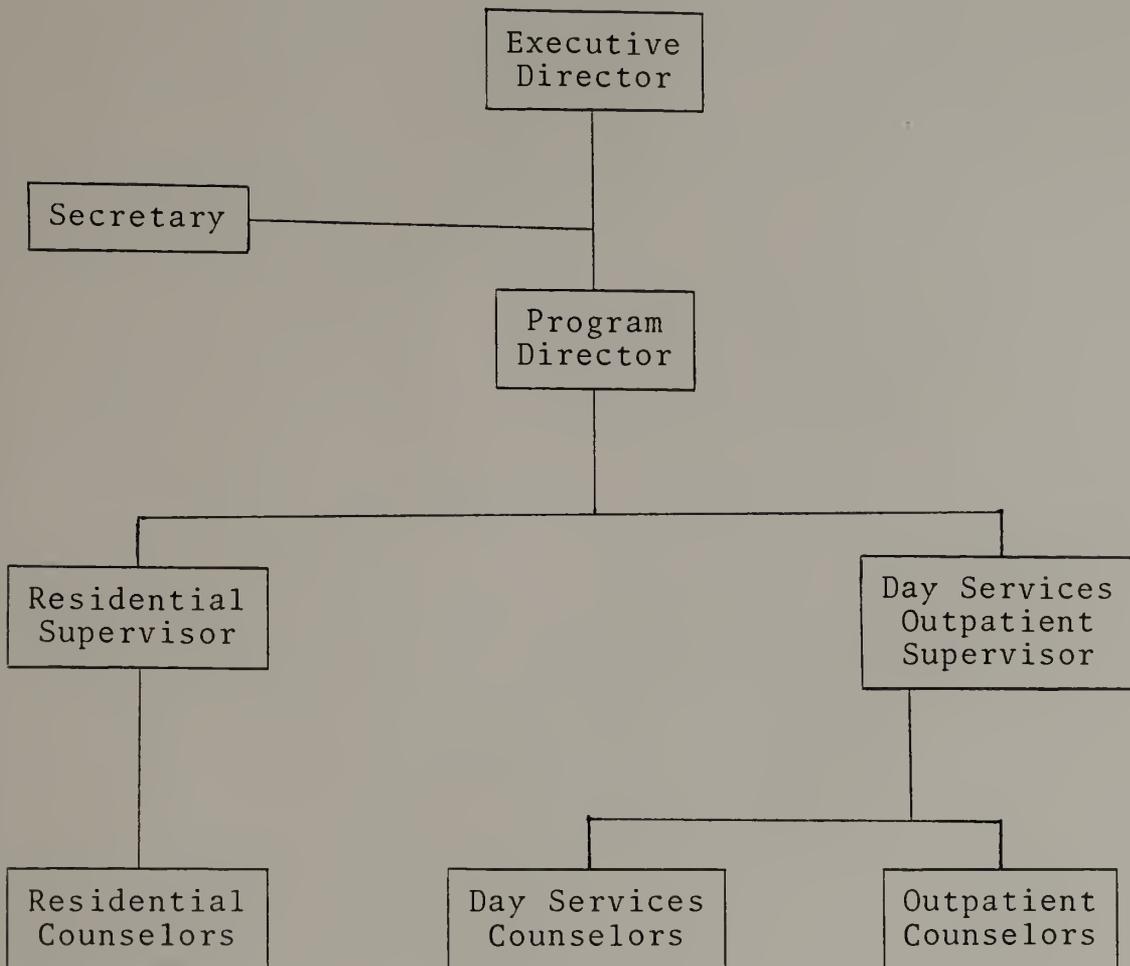
The Budget

Although slot-cost funding necessitated changes in budget approach and priorities, the concept of the budget as an instrument in the hands of the Director, who makes ongoing judgements regarding the spending plan, did not itself readily apply to the Youth Program. The funds that came into the Drug Treatment Unit were all channeled through the Community Mental Health Center's financial office to the D.T.U. administrative offices. It was the D.T.U. administration's role to apply financial plans and statements, usually through planning sessions with the D.T.U. Executive Director, Medical Director, and Component Director. It was the Administrator's responsibility to translate the issues and ideas into practical budgets, usually on an annualized basis.

The slot-cost formulas of funding and the day-to-day expenditures were not part of the Youth Program Director's

CHART 7

Changes in Organizational Structure
Resulting From Slot-Cost Arrangement



understanding or responsibility. The Component Program Directors made requests to the Drug Treatment Unit's Executive Director, who acted as "delegator" of all the Unit's resources. There were actually two levels to process requests through. The D.T.U. Executive Director would usually approve or disapprove requests based upon the merit of the idea or need for the item. Then the D.T.U. Administrator would determine whether it was financially practical, given the status of the budget.

Mission (Change of Focus)

Within this second phase, the program's sense of mission was also altered. Along with the changes in the funding arrangement and the movement to "concept," another new direction occurred. The research department of the National Institute on Drug Abuse (N.I.D.A.) was interested in accomplishing studies on the use of narcotic "antagonists" with young drug abusers as a method of treatment. To some degree, in the view of this observer, this was a violation of the priority of the original mission to reverse the need for drugs in juvenile abusers. Still, the leadership of the D.T.U. put together a proposal to dispense the "antagonist" drugs (Cyclazocine and Naloxone) within the Youth Program and report the results to N.I.D.A. In 1978, a research grant was awarded to the D.T.U. to

perform a two-year study using narcotic antagonists as a primary part of the treatment of a specific group of clients within the Youth Program.

The Narcotic "Antagonist" Study

Narcotic antagonists are compounds that selectively block the euphoric and physiologic effects of morphine-like drugs (opiates), such as heroin and methadone.

The narcotic antagonists used by the Youth Program were Cyclazocine and Naltroxone, themselves not addicting and "having no abuse potential or black market value." When administered to an individual who is physically dependent on opiates (i.e. addicted), a narcotic antagonist will precipitate the familiar opiate abstinence (withdrawal) syndrome. This syndrome can be reversed by a dose of an opiate substance. However, if a person who is no longer physically dependent on opiates takes a narcotic antagonist, he/she will be protected against re-addiction; even if heroin is used, he/she will experience no euphoria and will not develop opiate dependence. Having this protection, the person can return to the community, where rehabilitation can take place despite the endemic presence of heroin or other opiates.

The potential usefulness of narcotic antagonists in helping former opiate addicts remain abstinent was first

suggested by Martin et al. (1966) in An experimental study in the treatment of narcotic addicts with cyclazocine. The investigators found that Cyclazocine provided blockade of opiate effects for as long as 24 hours following a single oral dose, and prevented the development of physical dependence from repeated injections of morphine. They suggested that maintaining a detoxified opiate addict on cyclazocine would control the pharmacologic actions responsible for addiction and provide an opportunity for extinction of conditioned physical dependence and drug-seeking behavior (Wikler, 1965, 1973). In addition to its opiate blocking action, cyclazocine produces analgesia and dysphoric side effects. The latter are characterized by sedation, visual distortions, and racing thoughts. Tolerance develops to these side effects, but not to the narcotic-blocking action of cyclazocine. Abrupt discontinuation of cyclazocine after chronic administration results in characteristic withdrawal effects, but unlike opiate withdrawal, these effects are not associated with drug-seeking behavior.

The Youth Program's early trials revealed that cyclazocine's dysphoric side effects limited its accessibility to clients. These side effects could be minimized, however, by gradual increments in daily dosages over a period of approximately 21 days. Even with this gradual induction

schedule, some clients, particularly those with a history of schizophrenia, experienced dysphoric effects from the cyclazocine. The Program also found that with cyclazocine, almost all clients relapsed to opiate use within a few months.

With the completion of the study, the Youth Program stopped using antagonists as part of its treatment. The side effects and accompanying "bad stories" tended to create a resistance with the clients themselves.

Leadership

The antagonist research project had an impact upon the organizational structure and operations. The research was the prime factor in the recruitment of a new Youth Program Director. While the research staff and activities remained under the Director of the D.T.U.'s research component, it was felt at the time that in order to accommodate the research study, a director familiar with research studies and sympathetic to the research approach, and capable of coordinating the research and treatment aspects of the Youth Program, was necessary.

It was also decided that the treatment aspect of the Youth Program required a leader skilled in the "concept" model which the organization was now committed to. This decision resulted in the creation of two leadership

positions--Executive Director and Program Director.

The Drug Treatment Unit finally hired an Executive Director, another social worker who had previous involvement with the research component of the Community Mental Health Center. The Executive Director was to manage the research activity within the Youth Program as well as the external relationships of the D.T.U., C.M.H.C., and N.I.D.A. The responsibilities for managing the treatment aspect of the program was assigned to the Valley House graduate who had been the Assistant Director.

It should be indicated here that the observer became concerned at this stage over the issue of credentials, and the power attributed to and possessed by professions other than medical and in turn, began to wonder at the advisability and reasons for placing social workers at the helm of the Youth Program while physicians and psychiatrists typically headed the adult services. Even Valley House was overseen by a medical director.

Accountability

This second mixed phase of "concept" treatment, antagonist research studies, and the conversion of slot-cost funding ultimately left the program struggling to survive.

The problems and conflicts that developed were overwhelming. The dual leadership of Executive Director and

Program Director could not develop and maintain a healthy clarity of purpose. At this time, this observer was able to observe as a member of the D.T.U. parent organization, staff who remained open to the idea of complete separation of the Youth Program, albeit treatment or research oriented. That there were constant bickerings and battles between them, and many false starts and wasted efforts in trying to determine and set a rational course for the program.

When the research activity finally ended, the Executive Director became primarily saddled with the responsibility of fulfilling the N.I.D.A. treatment slot-cost requirements. N.I.D.A. was now totally committed to evaluating organizations according to slot utilization. Those organizations that were continually "underutilized" were put at risk of losing portions of their funding to organizations that could demonstrate "overutilization."

At this time, the Youth Program suffered from many problems. The Program's executive meetings now consisted of total staff; no agendas were present; people often arrived late; discussion was seldom focused; many conflicts were avoided; and a few differences of opinion, usually between the Executive Director and Program Director, consumed most of the meetings. Tasks were often assigned to committees without naming an individual ultimately responsible for calling such meetings, and with no date set by

which to give feedback. The other departmental meetings looked the same. Counselors were frequently out of their offices; others were clearly uncomfortable in middle management supervision roles. It appeared that the program managed both clients and itself, not by objectives but rather by interpersonal factors. However, in spite of the resulting chaos at the administrative level, there was an extended community of staff and clients, most staying relatively free from the use of opiates (at least in the beginning of the second phase, although it is not clear why this positive clinical effect persevered) in spite of a proliferation of gossip and inappropriate interpersonal liaisons among staff which complicated supervision and created tension. It suddenly was not an organized program, and seemed more like a large family with problems trying to stay healthy. Many clients of this period, most of whom had left the program once or twice and returned, viewed the program as being a family. The process was not clear and consistent, but many described using fewer and fewer drugs for longer and longer periods of time. It also was not clear to what degree the fantasy of inter-familial dynamics were essential to the maintenance of a drug-free state in these youthful clients.

It was at this time a critical interest from the parent organization (D.T.U.) arose and focused upon the

need for better management. Once the funding source monitors picked up what they considered mass management deficiencies, the program was put on notice to improve this area. Initially this resulted in the program spending its time dealing with the monitors' demands, i.e., clinical files, operation manuals, and other kinds of paper tasks, in lieu of dealing with clients.

As a result of all the time spent attending to management demands by the funding source and the parent organization, clinical goals of treatment suffered greatly. As the program failed to produce the desired goals, they were continually told they were management deficient. In other words, when the program was plagued to do everything other than what it did best, i.e., treat people, it was blamed for failing to effectively treat. This is similar to the situation described by Attewell and Gerstein in which the Methadone Clinic was considered deficient by not meeting regulatory policies at the expense of client treatment. Regardless of how skilled the program managers were or how sound their practices, it was as if they were setting up a straw man by suggesting that what was at fault was the absence of program management.

It is a generally accepted axiom in the field of organizational dynamics that one must pay attention to management. That leaders would do well to study management

techniques in regard to the maintenance of the quality of client services. But the unanswered question at the time for this observer is: Was management, and management deficiency, the source of the critical problems?

This observer, prior to this, had been involved in and had observed programs and organizations that were highly structured. Where the chain of command was clear and the program was in conformance, each unit had objectives and goals; staff meetings occurred with regularity and had agendas and minutes; policy directives were clearly posted; there was pertinent charts and operations manuals; and all staff had formalized credentials. From a management standpoint, it appeared as if they were superior programs. However, discussion with clients would reveal that the clinical problem, their addiction, was not improved. In fact, often these clients would ridicule the intent of the programs, accusing them of giving priority to the generating of funds and the survival of staff rather than the needs of the clients. This, too, is similar to the situations described by Attewell and Gerstein.

In many of these programs, the original mission of treating and recovering young people from drug abuse had been put aside in deference to supposed organizational needs. Regardless of the organizational structure, the public need, or nobility of the sense of mission survival

via "body count" became the prime focus. This probably would not have been a major problem if there were still enough clients to go around; but in the end of 1978 and all of 1979, the Youth Program experienced a severe loss of client applicants. (National figures on drug abusers indicates an unexplained drop during this period.) The Youth Program was now considered a full blown "concept" therapeutic community, like Valley House, which also experienced a severe loss of clientele.

Some theories put forth at the time for the loss of clients were:

1. That the legal pendulum had swung in a more liberal direction, and the threat of serious "jail time" or long term "institutional care" was just not as strong as in the late sixties and early seventies when there was a rush of clients coming into programs.

2. That the programs themselves had performed successfully, and that the drug problem was on the wane.

3. That the programs had performed so poorly that the addicts and referral sources decided to stop attending them, preferring to fall back upon the jails, other institutions, and streets.

In this observer's view, what contributed greatly to this problem was that with the adoption of slot-cost funding, the Drug Treatment Unit, though bargaining in good

faith, had to over-project its needs in order to maintain its level of resources. In order to continue its grant level of funding under the "slot-cost" management, the D.T.U. programs had to increase their client load. The total cost of the Methadone Program at the time of this change was approximately \$400,000.00 annually. (This included the inpatient beds within the C.M.H.C. which were considered as matching funds.) To maintain the level of funding, the program now had to maintain an active caseload of over 250 clients where it had been serving under 175 clients all along. The Valley House Program found itself in a similar situation.

The Valley House budget, at this time, was approximately \$200,000.00 annually with an active client caseload of 25 clients. Under the new slot-cost funding requirements, the program was expected to now maintain an active caseload of at least 40 clients. The Youth Program caseload became 30 residential clients, 15 day service clients, and 24 outpatient clients.

The Methadone Program was able to keep up due to a continued demand for its services. This in turn had an effect upon the number of clients left available for Valley House. Valley House, after a time, decided to lower the age restriction from 18 to 16 years old in order to increase its pool of potential clients. This lowering of

the age limit for admission put Valley House in competition with the Youth Program for clients as well. These changes set the stage for open competition between all Drug Treatment Unit programs similar to the "range wars" described by Attewell and Gerstein (1979). These struggles led to the displeasure of referral sources which had a negative bearing upon the utilization of all programs as referrals diminished.

Staff

The staff at this time was made up of the residential counseling staff and the day services and outpatient counseling staff. They suffered from a loss of clear leadership and what seemed an irrational purpose, i.e., "turnstile counting" of clients. As the risk of losing funds became greater, the hidden message in all D.T.U. meetings became "keep the numbers up." The executive level of all D.T.U. components were given this message loud and clear. This kind of orientation had resulted in an erosion of faith in the ability of leadership to maintain the original sense of mission of the agency. This began to evidence in a variety of behaviors. There was a constant abuse of time; people were always late or absent. Interpersonal liaisons between staff became more common, and there was constant bickering in staff meetings.

The budget at this time became more like a club that the D.T.U. Administration wielded at the components within all D.T.U. staff meetings. Every issue tended to become a major negotiation, especially when attempting to replace staff. The administration had not anticipated slot-cost funding would have such an impact throughout the organization, especially in clinical services. What was not first realized was that these programs had developed prior to slot-cost funding and were not designed from sound business principles. There was almost a naive altruism in the start-up years. Initially, there were basically two types who entered the drug field. One type included those who operated as if they were going off to solve the "drug war," and winning meant there would no longer be a "drug problem" or a need for "programs." The other group included people committed to treating the "casualties" of the "war" and tended to realize it would be a continuous battle within our society. This latter group usually viewed treatment in an evolutionary process. It was this latter group who adopted the attitude of "keep the programs filled at all costs," so that the other clinical staff continually felt compromised in making judgements to satisfy the census and administration's demands, rather than the needs of the clients. Clients who were not committed to treatment, who were merely avoiding other programs or institutions, were

now being maintained within the program regardless of poor performance. Deals were made with clients and referral sources in order to improve the census. The clinical intent and boundaries of the program became blurred in the need to fill programs.

C H A P T E R VI

PHASE III: THE SURVIVAL PHASE

"Clients At All Costs"

This phase actually began with the end of the antagonist study project in 1980. Within the final phase of this study, there were additional changes within the environment. The federal and state governments agreed to shift authority over programs to the state government and the Connecticut Alcohol and Drug Abuse Council (C.A.D.A.C.), developed as a state bureaucratic agency. C.A.D.A.C. over D.T.U. (taking N.I.D.A.'s role) became the direct funding, policy making, and monitoring agent to the program serving a role similar to that of N.I.D.A. The funds and policies were now flowing through and being overseen by an organization in the state capitol in Hartford instead of the Nation's capitol in Washington, D.C. This was accomplished at a time when funding for drug and alcohol activities was threatened with a reduction at the federal level in the hope that state governments would provide some funding support as well.

Accountability

The accountability by C.A.D.A.C. for the Youth Program concentrated into three areas: financial, administrative/managerial, and clinical. Previously, N.I.D.A. had established standards within these areas ranging from formal financial audits and spending plans to operating policies and documented procedural guidelines, to census encounter reports, and treatment planning. The funding of all N.I.D.A. programs became contingent upon ongoing compliance within these policy areas. The responsibility for overseeing and monitoring was shifted to C.A.D.A.C. The Drug Treatment Unit viewed itself as maintaining an active and primary role of monitoring all matters pertaining to funding and became the overseer of the Youth Program's compliance with N.I.D.A. and C.A.D.A.C. standards.

The responsibility for implementing the programs and operating within compliance to the policies fell to the program executive directors. The Directors' job remained essentially the same even in the area of finance which was maintained within the D.T.U. administration.

Mission

The Youth Program saw another change in focus following the ending of the antagonist project.

Following the loss of the research study, the Drug Treatment Unit maintained interest in research as it moved into studies on detoxification methods and research into treatment methods for cocaine abusers. The Youth Program no longer a part of the D.T.U.'s research was continued in a total treatment service mode still focusing, at this time, on Heroin abuse.

This third phase involved a shift to a rehabilitative model which had its roots in the therapeutic community approach to drug treatment begun by such programs as Synanon and Daytop. It was a model of total intervention in that it was residential and very structured. It did utilize a form of the socio-psychological approach from the first phase but only within an aftercare segment of the program which followed the completion of the residential portion.

This model did not view society as the culprit, as did the model in the first phase, but considered the drug abuser as the "wrongdoer." The need for treatment was viewed as a need to be restored to a society in which the human condition would always create deviants and criminals.

Treatment was seen as confession, and/or problem confrontation, repentance, prayer and meditation, reality therapy, and social rehabilitation; the stated goals being a reinvolvement with society and abstinence from drugs.

This model involved stringent maintenance of controls by the program. Basic to all residential programming is the problem that people are not apt to give up their freedoms willingly. The program responded by building a network of referral sources who acted as pressure controls to the deviance of the clients. Courts, jails, families, and schools were enlisted by the program almost as primary consumers. For the client, staying within the program became based upon the amount of pressure or coercion these sources could apply upon the client in order to obtain their cooperation.

Thus, it was with this external support by a group of cooperative referral sources which helped the program improve its utilization and retention of clients.

Within this final model though the staff were seen as therapists, the clients were actually expected to "treat" themselves. It was seen as the client's right not to be treated as "junkies" or "criminals" and as their duty to become new and "better" people.

Leadership

The leadership that proceeded from this confrontative milieu approach was essentially different from prior disciplines.

With the end of the antagonist research study, the Executive Director no longer felt viably involved in the program and decided to accept a position in another state leaving the Valley House graduate who was the Program Director in charge of the program.

This director had worked his way up from client of the Valley House program to staff member in the first two years; now he was put in total charge of the Youth Program. Ex-addicts, like himself, were subsequently used in various treatment and service capacities throughout the D.T.U. at this time; at Valley House, however, ex-addicts ran the total program. The director and all the staff were ex-addicts who had either come from other treatment programs or had risen through the ranks of the D.T.U. programs. When the Youth Program, in the first phase, was experiencing problems, this director was loaned to the Youth Program in the hope that he could assist in developing structure and controls similar to those used at Valley House. Prior to this, however, ex-addicts had not received positions of power in the D.T.U. outside of Valley House. Each component other than Valley House was run by a professional with ex-addicts placed in lower positions, usually as counselors. This director initially had some difficulty overcoming his ex-addict identity and thus was made

Program Director under the social worker who was appointed Executive Director.

This director was able to impress upon the Drug Treatment Unit seniors that the program was making a serious effort to improve its utilization and its retention of clients. This director was also able to make indicated changes that previous directors under existing organizational structure were not able to make. He gathered data in meetings with referral sources and executed changes within the program which did improve the amount of referrals and the retention of clients. Also, by the time he became director, the policies of urine collection had loosened and clients were now required to "drop" urines only once a month. This made the program appear less punitive to the clients. He also lowered the residential stay time from 12 to 18 months, which was similar to Valley House, to 4 to 6 months with 2 months of day program followed by 4 months of outpatient status. This meant that the breaks from family and home would not be as long. He also established home visits each weekend following 30 days in residential treatment. These changes were a major departure from the original model and effected an increase in program utilization.

Due to past failures and failed expectancies, referral sources were desperate for any indication of treatment

success and responded favorably to the initial promises of this approach.

The program, out of a need to demonstrate positive impact, was now admitting clients where severity of drug abuse was with substances considered less addictive than heroin. These clients were younger, coming mostly from the Juvenile Court or the local Division of Children and Youth Services. The majority had problems stemming from family and school and had used some form of drug (mostly marijuana).

Perceiving this model as based on an unusual opportunity for self help, punishment for violations was exclusion to the point of being refused reentry. However, the policy of reentry refusal could not be maintained since typical behavior of young drug abusers involves a large incidence of recidivism. The staff had to come to accept that "running away" and reversion was to be expected amongst young drug abusers. Thus, rules were liberalized and clients accepted back in the program with little resistance or punishment.

This director was forced to modify his original rigid ex-addict proscriptions and made changes that would ensure basic survival of the program. His greater flexibility and pure survival tactics allowed him to effectively handle the pressures and problems that had plagued the

directors of Phases I and II. He championed such changes as:

1. The loosening up of the urine policies, though not created by the Director, certainly was beneficial to the utilization and attitude of the clients toward the program.

2. The lowering of the residential stay time was also a major practical step to improve utilization, which it did.

3. The acceptance of clients with softer drug problems also had a positive impact by offering far more clients to the program.

4. The diplomatic meetings and approach taken with potential referral sources was also another accomplishment of this Director.

All these interventions were expressly approved by the Drug Treatment Unit and the National Institute on Drug Abuse (N.I.D.A.) and the Connecticut Alcohol and Drug Abuse Council (C.A.D.A.C.).

Staff

Throughout this study, the staff included adult and adolescent professionals and ex-addict para-professionals. Still at this stage with the treatment census down all over the country, the most critical problem the

organization faced was attracting clients.

When faced with problems coming from continued client deviance and loss of interest in the program, the organization initially added the enticements of (1) an open format whereby clients could come and go without close supervision, and (2) expanded recreational and social activities. This had the effect of the clients receiving the impression that they were in the program to "enjoy themselves" so that any attempt to impose restrictions or treatment regimens were met with resentment. However, this surrender to client interests seemed to enhance drug usage and literally threatened the existence of the program.

In reaction in the second and third phases, the treatment staff tempered their overall liberal acceptance of client deviance. They became assertive in what would be tolerated and accepted as client program behavior. This active staff role was welcomed by the D.T.U. seniors and the N.I.D.A. monitors. However, it initially produced conflicts with the clients and threatened their acceptance of the program. The open passiveness of the first phase threatened the environmental and community support of the program, and the more rigid style threatened enrollment of the clients. But, by this time, it was obvious that the staff had to react in ways that were not necessarily

acceptable or appealing to the clients if they were going to maintain a program.

With the changes that this Director made, the program became a more traditional authoritarian system that allowed for discipline, recreational, and social activities as long as conformity to established boundaries was maintained. Thus recreation became a privilege following the work of treatment or therapy. The staff ultimately found that the crackdown on the deviant antics within the program met with the approval of many clients. They seemed to be able to find safety and comfort within the structure and boundaries.

As the staff became able to maintain a consensus on objectives and gained more experience, they were able to provide a more unified approach to the deviance and conflicts within the program.

C H A P T E R V I I

SUMMARY AND CONCLUSION

Prior to the development of the Youth Program examined in the study, the thrust of the Drug Treatment Unit had been on the adult "hard core" street addict, as was the focus of most public concern. The services available to addicts were constructed as models for specific addict populations. Methadone maintenance and the therapeutic communities, though distinct in their operations, were both designed for adult heroin addicts. Both models of treatment, however useful, were not available to the population of younger drug abusers the Youth Program was developed to serve. These clients were not only younger in age, they were also less experienced at drug-taking and its potential social, psychological, and physical consequences. It should be stated that there still exists populations of drug abusers such as the hallucinogenic or barbiturate abusers for which viable treatment does not exist. Research presently is being concentrated in the direction of services for cocaine abusers which now dominates the focus of public concern, but which as yet has not become a major factor in adolescent drug abuse.

At the time of the development of the Youth Program, there was a long standing dispute among professionals, both legal and medical, as to whether young addicts should be dealt with as criminals or as sick people or just left alone to become older, more experienced, and hopefully more desperately in need of treatment whereby existing models would then favorably apply.

The time of this study can actually be considered one organization's search for a viable treatment model for young drug abusers. It was a period which carried the organization through three distinct models of treatment.

Environmental policies enacted as operational goals played a major part in striking down each treatment model, along with its leader. Program difficulties with compliance to governmental policies is not unique to the D.T.U. programs; as indicated in the paper Government policy and local practice (Attewell & Gerstein, 1979) in which government policies are seen in direct conflict to the therapeutic mission of the program. Each phase of the organization was actually a restructuring of the organization to better comply with governmental policies.

Policies such as the "urine drops" which were originally developed for the purposes of control and accountability by the American Food and Drug Administration (F.D.A.) and the Bureau on Narcotics and Dangerous Drugs

(B.N.D.D.) to regulate methadone dispensing when applied to the Youth Program alters considerably. Without question, it is important to ensure that methadone is not taken in combination with other drugs or being diverted to the black market. The testing of urine can be a safeguard to these issues. Within the methadone program, the urine policy was also resisted and resented, but it became clear to the clients that "you give up the urine" and "we give up the methadone." It became a concrete bargain with an immediate payoff. The Youth Program clients were only able to perceive the "urine drops" as punitive policing with no possible gains.

The second phase attempt at a medical model approach similar to the methadone model yet utilizing non-addictive opiate antagonists of Cyclazocine and naltroxone failed miserably as a model for adolescents and is now considered only as a model for the most motivated addicts, usually following methadone detoxification (Kleber, 1973).

The third phase involves the advent of the non-professional ex-addict administration and treatment phenomenon. A drop in the incidence and census of residential services programs contributed substantially to this change. With staff who had "been there," it was conceived that treatment and residential programs would be more attractive. In this perception, both medical and

non-medical staff were in agreement at this time.

The initial failure of concept approach to enroll a significant increase in clients resulted in a shift from the original "hard core" heroin clientele to a softer more poly-drug group. This enhanced the possibility of program survival by expanding the pool of potential clients.

These changes were born out of the organization's basic and primary need to survive, not necessarily out of a desire to improve treatment and better accomplish the original goal of reducing drug use in young people. Nevertheless, the organization experienced a major metamorphosis within the time of this study.

As indicated, the organization began out of a need to respond to the young people coming into the Drug Treatment Unit seeking help for drug abuse. The program began as an outpatient clinic, utilizing a socio-psychological approach to drug treatment. This approach at the time was considered "least radical" in comparison to other D.T.U. programs of methadone and Valley House.

The format was loose and open in the first phase with a minimal amount of structure and no reliance on chemical or "drug therapy." The client was perceived generally by program staff as suffering from a victimization of social forces beyond their control. Their drug abuse was considered a manifestation of their disenchantment with a society

which confused, betrayed, exploited, and/or abandoned them. Involvement with drugs was considered similar to that of involvement in a career for people who had little alternative. Drug abuse was considered society's problem in that it created deviants and criminals and reinforced personality disorders. Though the program considered addiction to a drug a physiological matter requiring medical detoxification, the real threat of addiction was perceived to be in the person, not in the drug. Society and their families were considered to be contributing to the distrust of social institutions, weak ego functioning, defective super ego, etc.

The treatment itself ranged from medical health assessments, social casework, and group and individual psychotherapy. The staff, at this time, felt that the psychotherapy was an optional consideration requiring the full cooperation of the client. Forced psychotherapy just did not work. Social and behavioral change of some kind was considered eminent if treatment was to be successful.

One of the underlying goals of this approach was to change society, to alter it so that social conditions did not exist which create deviants and criminals. For the client, the goal was more simple; to improve their information in an attempt to change their attitude and behavior and then move them to a place where they might be able to

begin to use their full potential.

This model suffered from a number of things beyond the handicap of urine collecting and the major disadvantage of being located directly next door to the methadone program. The most obvious is that social change is very difficult to achieve and as already indicated in other models such as Lexington and Fort Worth, psychotherapy is just not that successful with addicts (Musto, 1973).

The antagonist research project introduced a medical model approach which viewed the client as suffering from a chronic disease in need of medical treatment via substitute drugs. This model was in direct conflict with the rehabilitative "concept" model which considered any drug taking as weakness and wrong, and as a continuation of "junkie" behavior. This created major problems for the leaders and staff as they attempted to blend the research and treatment into one organization.

The antagonist (cyclazocine and naltroxone) project was relatively short-lived, mostly due to the undesirable side-effects and its extreme difference in effect from methadone. The side-effects and non-opioid action of the antagonists were acted out against by clients through continued deviance and noncompliance to program boundaries. With the medical model's view of drug abuse as a health problem and the "concept" model's view of it as an attitude

and moral failure problem, the clients and staff found it difficult to come together in a rational approach.

In developing the Youth Program, the leadership and everyone involved shared in the high expectations of the first model in the "Missionary" Phase despite its having such a "low intervention" capability, and the conflict drag of the program's location. It was not until the program began experiencing serious problems that opinion began to take into account the location and complexities of a drug problem along with other innate problems given to the struggle of adolescence. This rational view was initially lost within the struggle to maintain power and control.

The mixed "hybrid" second phase actually split the leadership between the task oriented "concept" program leader and the more democratic leader of the research project. This split did not serve either well, but instead created confusion among the staff and clients and made it impossible to bring the research and treatment projects together into one organization with a common goal.

The split in leadership led to a struggle for control by both leaders. This resulted in constant bickering and an irrational craziness that ultimately had a bad effect upon staff, clients, and referral sources. In other words, "a house divided cannot stand."

Conclusion

In the time of this study, the Youth Program and the field of drug abuse has essentially changed. This is evidenced within the 1983 budget of the National Institute on Drug Abuse (N.I.D.A.), where over 60% of the total 275 million dollars was spent to fund treatment for over 200,000 people in over 1,300 individual programs located in all parts of the country. It is difficult to predict the continued development of the Youth Program or the possible benefits and deficits of the partnership between the state and the federal government. What is certain is that if this partnership is to continue, it will be important to develop better techniques to meet the needs of youthful drug abusers.

It is not yet assured, but it seems likely that the national commitment to dealing with drug abuse will remain steady. Thus, the program should be able to build on the foundation of the last decade with less worry of the whole effort being "defunded."

Not only is it unlikely that the widespread public wish to "end the drug problem" will be realized, it is probable that at least for the next decade the overall levels of illicit drug use will continue to rise as they have over the last decade.

Finally, the Youth Program as an organization was both interesting and viable. It was viable in the sense that in the third "Survival" Phase, it did begin to approach its goals of maintaining an acceptable client census, reducing "dirty urines" and extending its retention of clients. Although the program did not accomplish all of its originally stated goals, given their nature, the program can hardly be considered a failure. The program clearly existed at the convenience of the elements within its environment. Existence depended upon the Drug Treatment Unit's pursuit and agreement to accept federal funds and to permit treatment for young drug abusers to occur under its auspices. These influences, along with others described in this study, served to set up boundaries or limits in which the Youth Program had to operate. The program's continued operation is still dependent upon its relationship with its environment and its contribution towards social change through the people it treats and the work it does within the community.

The Youth Program spent the time of this study struggling for a stable, respectable identity.

Recommendations

The major recommendation coming from this study centers around the conflicts emanating from the policies

of slot-cost funding and the antagonist research project. It is essential, if conflicts are to be avoided in the future, that the leadership maintain an active ongoing long range plan with the agencies in its environment, especially regarding potential changes in policies and future emphasis.

It is important that the leadership develop to where it is an integral part of ongoing changes rather than subject to them. This could be assisted by the establishment of such a plan. This plan could then be reviewed ongoing with the agencies in the environment and revised and updated given their input.

From an organizational viewpoint, it is essential that the leadership clearly and honestly spell out the primary purpose of the organization and build in mechanisms for reality testing. One such mechanism could be occasional staff-evaluation sessions where the staff could assess the progress toward stated goals and make necessary adjustments to improve organizational functioning.

It is difficult to offer strategies for improving the relationship of the Youth Program with its environment since, on the whole, the program did fairly well. In light of the continuing increase in drug addiction, the program, however, may benefit by involving itself more directly with funding and other regulatory agencies in the

hope that everyone involved might gain a clearer and better understanding of expectations and future interests. The Drug Treatment Unit could then evolve to an additional role of support, consultation, and advising on strategies and plans for meeting future goals--planned growth being essential to survival.

Another major recommendation coming from the limitations of this study is that the impossible task of evaluating program performance could be made less impossible if follow-up studies on the clients were developed. This data could facilitate overall evaluations and contribute to the self-evaluation process.

The program should also support cross-fertilization and encourage staff to attend training programs and workshops, observing methods and policies especially relevant to adolescents. This would add to the overall effectiveness of the program.

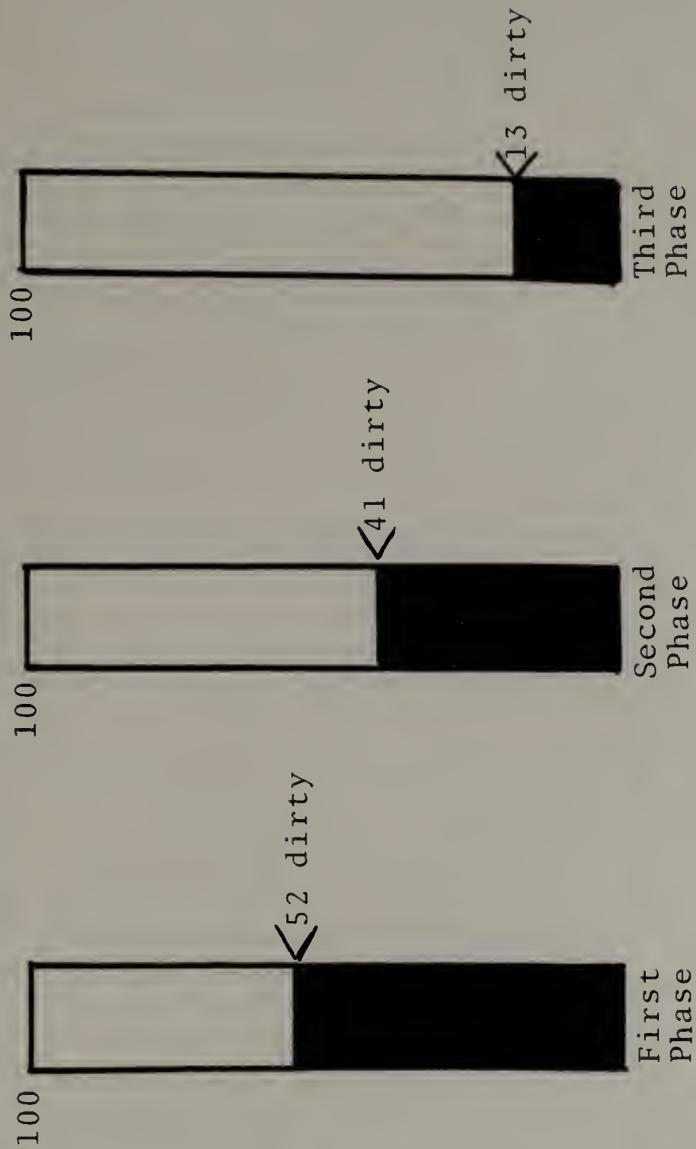
APPENDIX

Performance Graphs and Charts

The following sub-section contains charts and graphs which reflect the performance of the Youth Program throughout the period of this study.

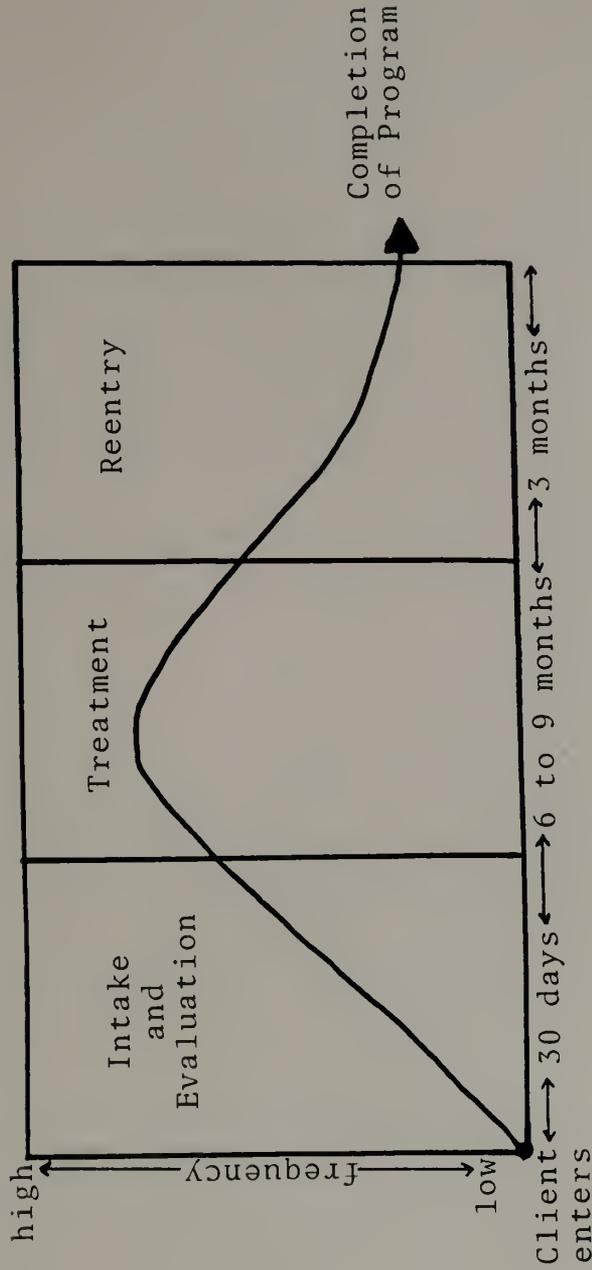
DISPLAY 1

Graph of a sampling of 100 urinalysis reports per phase upon clients that have been registered at least 60 days in each phase.



DISPLAY 2

Frequency of Encounter (Ideal Graph)
(sample)

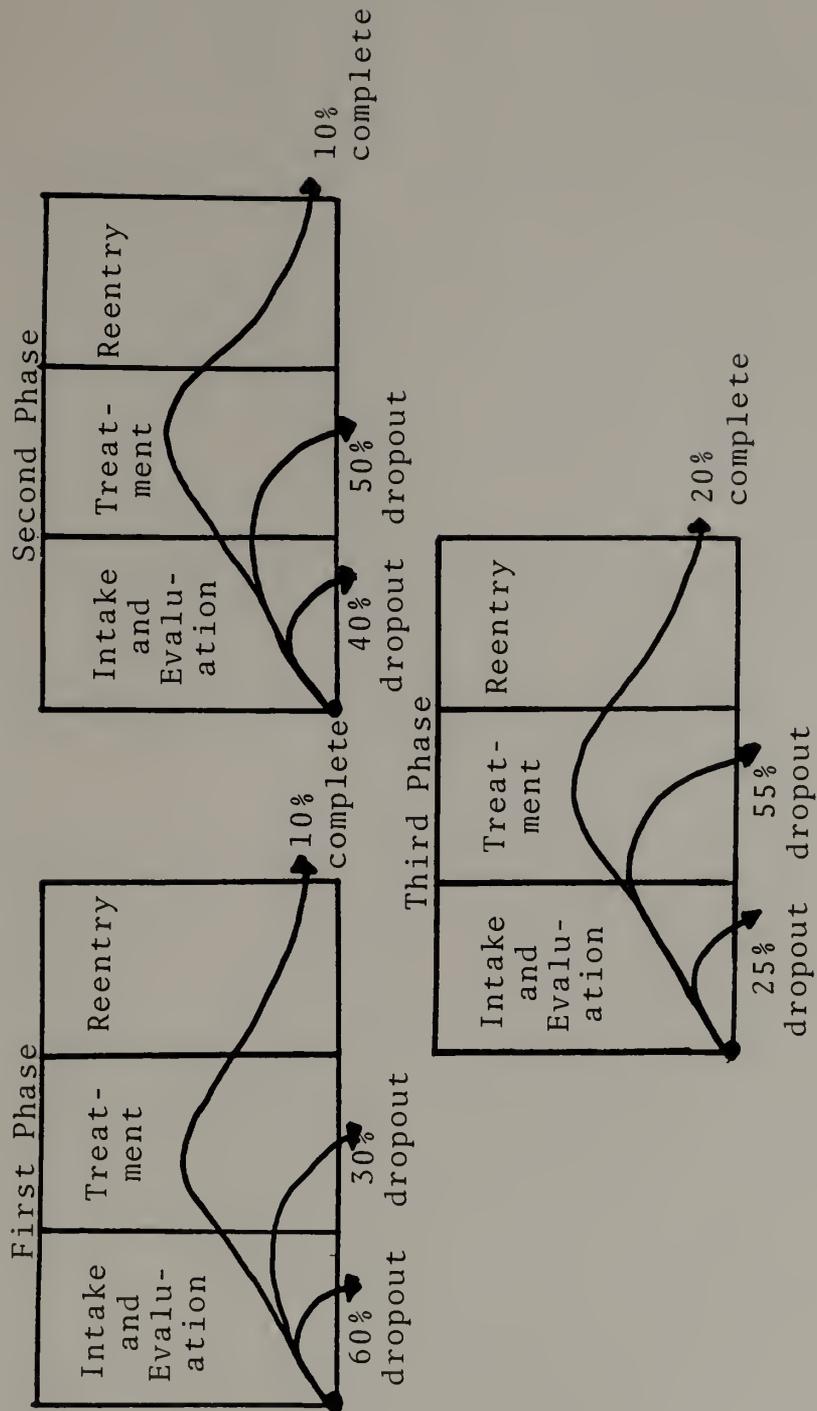


Client enters program ideally frequency of encounter increases to optimum performance during treatment, then diminishes to completion of program.

DISPLAY 3

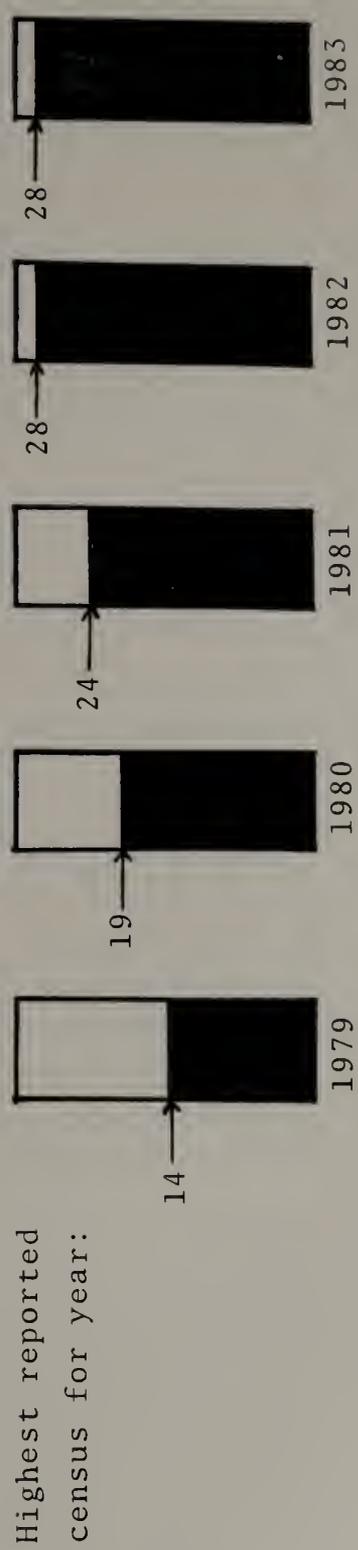
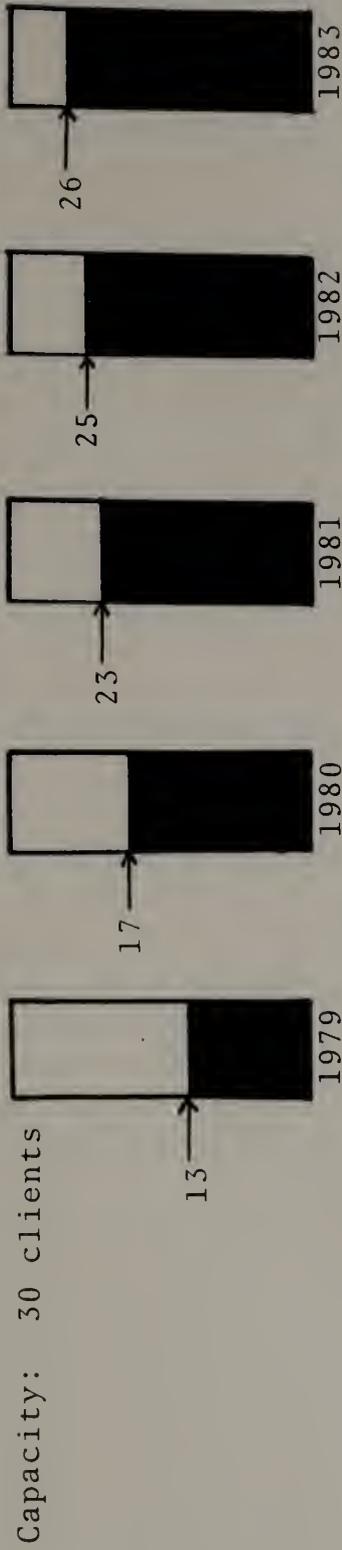
Frequency of Encounter (Three Phases)

30 clients sampled per phase



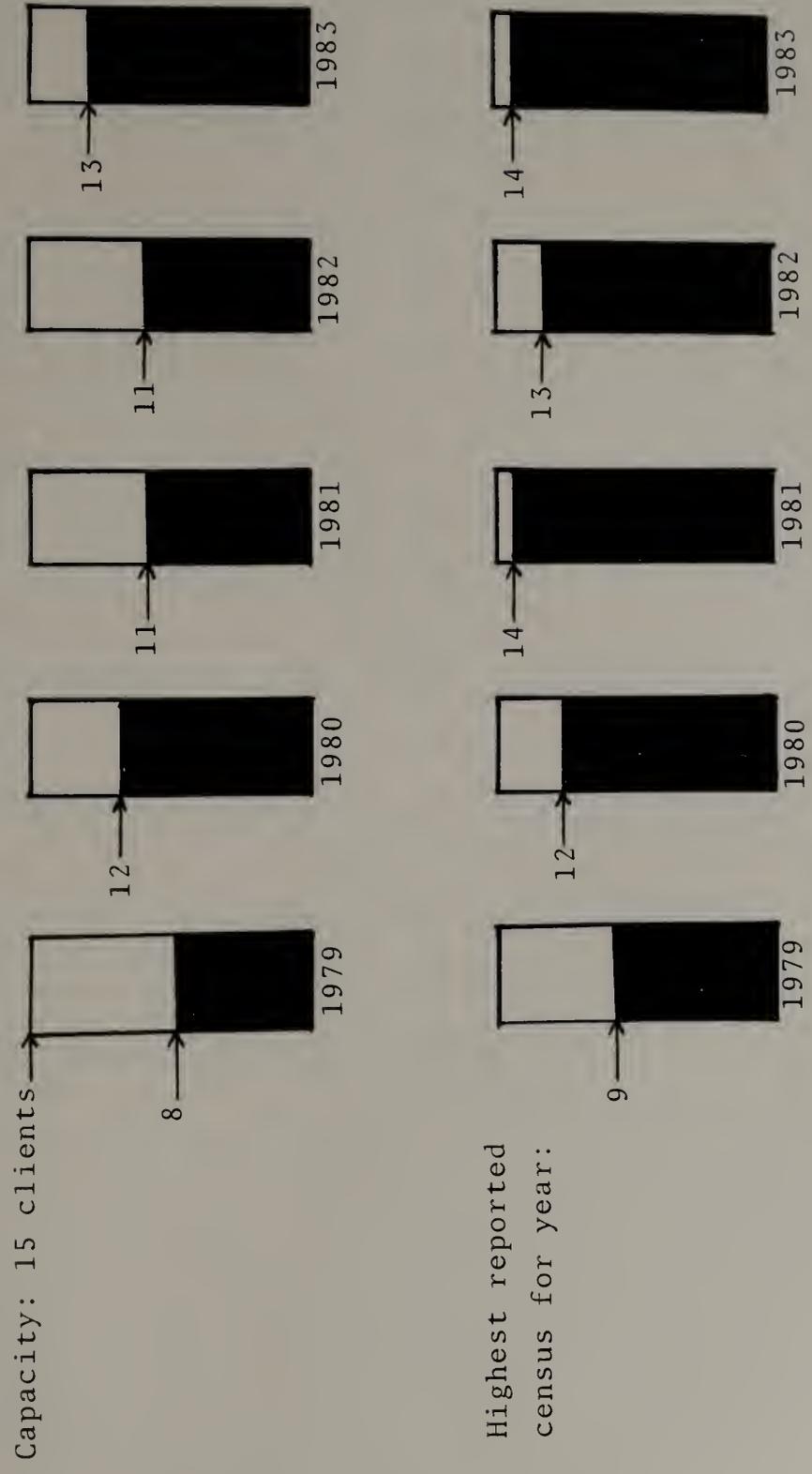
Display 4

Utilization Totals (Residential)



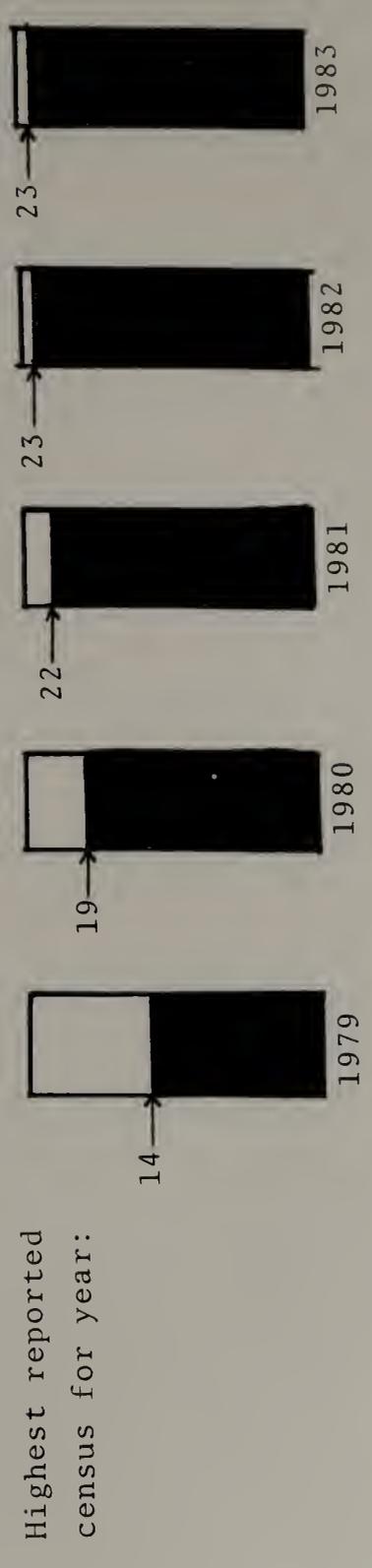
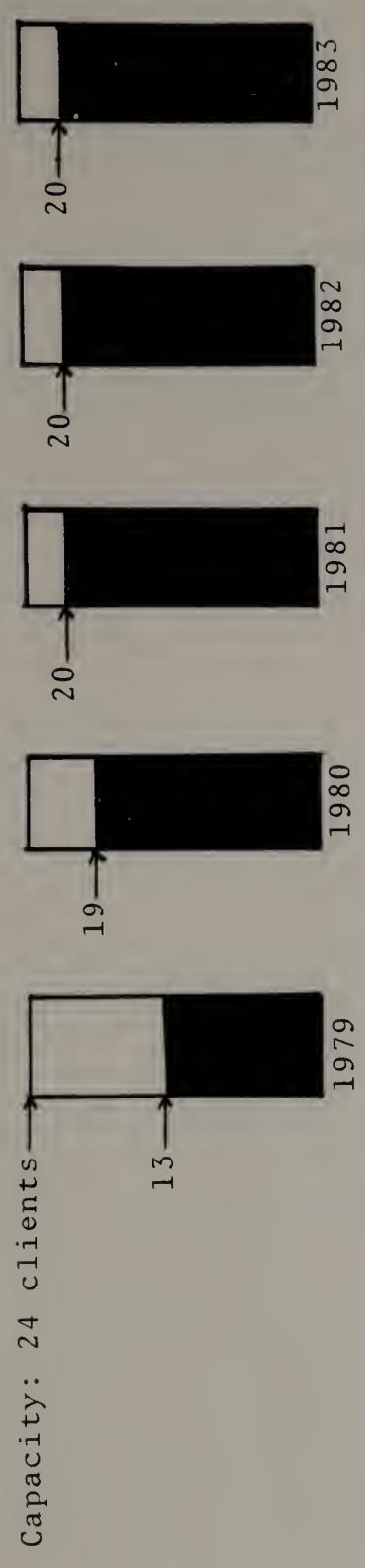
DISPLAY 5

Utilization Totals (Day Care)



DISPLAY 6

Utilization Totals (Outpatient)



The Budget--Phase III

The Youth Program had a three-part budget split between the residential, day and outpatient services. The most comprehensive was that of the residential section which took into account the 24-hour a day care and feeding responsibility for each client. The budget was broken primarily into three categories:

1. Personnel (salaries and fringe)
2. Space (residential)
3. Supplies
 - a. Groceries
 - b. Lab
 - c. Domestic
 - d. Office
 - e. Recreational
 - f. Educational

A. Residential

(Funding = 30 slots @ \$5,000 each = \$150,000.00
hard cash)

1. Personnel (salaries and fringe benefits)

a. Executive Director (1/3)	\$ 6,000.00
b. Program Director (1/3)	5,000.00
c. Quarter-time Psychiatric Consultant (1/3)	2,000.00
d. Secretary (1/3)	3,000.00

e. Residential Supervisor	\$11,000.00
f. Counselor	9,000.00
g. Counselor	9,000.00
h. Counselor	9,000.00
i. Counselor	9,000.00
j. Live-in	7,000.00
	<hr/>
Total:	\$70,000.00
10% Fringe Benefits	7,000.00
	<hr/>
Total:	\$77,000.00

(Positions a, b, c, and d were split into thirds and spread equally between the Youth Program's residential, day services, and outpatient budgets.)

2. Space (including heat and utilities)

\$2,000 per month x 12 = \$24,000.00

(This was rented space within a three-story residential dwelling.)

3. Supplies:

a. Groceries (30 clients @ \$2.00 per day x 365 days = \$21,900.00)

(These were purchased through contracts with food warehouse vendors.)

b. Travel = \$2,000.00

(Out-of-state travel was discouraged at this time. Most traveling occurred to in-state

meetings and training sessions.)

c. Laboratory (urinalysis screening)

30 clients x \$6.00 per test per month =
\$2,160.00

(All N.I.D.A. funded drug treatment programs were required to perform and record urinalysis screening for illegal drugs.)

d. Communications (telephone) = \$2,400.00

e. Office and cleaning supplies = \$5,540.00

f. Indirect cost: 10% of \$150,00.00 = \$15,000.00

(There was a 10% charge by the C.M.H.C. and the D.T.U. applied to each D.T.U. component budget as an administrative overhead cost for managing the contract.)

Totals:

1. Personnel (salaries and fringe)	=	\$ 77,000.00
2. Space (rent and utilities)	=	24,000.00
3. Supplies (groceries, travel, laboratory, communications, office, and cleaning)	=	34,000.00
4. Indirect cost	=	15,000.00
		<hr/>
	Total:	\$150,000.00

B. Outpatient

(Funding = 24 slots @ \$1,700.00 each = \$42,500.00 hard cash)

1. Personnel (salaries and Fringe benefits)		
a. Executive Director (1/3)	\$ 6,000.00	
b. Program Director (1/3)	5,000.00	
c. Quarter-time Psychiatric Consultant (1/3)	2,000.00	
d. Secretary (1/3)	3,000.00	
e. Outpatient Day Program Supervisor (1/2)	5,500.00	
f. Counselor	9,000.00	
		<hr/>
	Total:	\$30,500.00
	10% Fringe Benefits	3,050.00
		<hr/>
	Total:	\$33,550.00
2. Space (offices and rent and utilities)	=	\$ 1,200.00
(This was an office within the Youth Program charged at \$100.00 per month.)		
3. Supplies:		
a. Travel	=	\$ 1,800.00
b. Laboratory (urine screening)	=	500.00
c. Telephone	=	600.00
d. Office supplies		600.00
4. Indirect Cost (10% of \$42,500)	=	\$ 4,250.00

Totals:

1. Personnel (salaries and fringe)	\$33,550.00
2. Space (rent and utilities)	1,200.00

3. Supplies (travel and Laboratory)	\$ 3,500.00
4. Indirect cost (10% of budget)	<u>4,250.00</u>
Total:	\$42,500.00

C. Day Program

(Funding = 15 slots @ \$2,500.00 each = \$37,500.00)

(This was primarily a salary budget. All other areas were absorbed by the residential and outpatient budgets.)

1. Personnel (salaries and fringe)

a. Executive Director (1/3)	= \$ 6,000.00
b. Program Director (1/3)	= 5,000.00
c. Quarter-time Psychiatric Consultant (1/3)	= 2,000.00
d. Secretary (1/3)	= 3,000.00
e. Outpatient Day Program Supervisor (1/2)	= 5,500.00
f. Counselor	= <u>9,000.00</u>
Total:	\$30,500.00
10% Fringe Benefits	= 3,050.00
10% Indirect	= 3,750.00
Miscellaneous	= <u>200.00</u>
Total:	\$37,500.00

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